# Table of Contents

**CHAPTER 1: INTRODUCTION**

Welcome..................................................................................................................9
About This Manual ..................................................................................................9
Legal Requirements .................................................................................................10
Contacts ..................................................................................................................10
Before Rendering Services ......................................................................................10
After Rendering Services .......................................................................................10
Operational Standards, Requirements and Guidelines ...........................................10
Additional Resources ............................................................................................11
Accessing Information, Forms and Tools on Our Website .....................................11
Using the Provider Manual .....................................................................................11
Websites ..................................................................................................................11

**CHAPTER 2: LEGAL AND ADMINISTRATIVE REQUIREMENTS**

Proprietary Information ..........................................................................................12
Privacy Practices ......................................................................................................12
Misrouted Protected Health Information ................................................................12
Updates and Changes ..............................................................................................12
Nondiscrimination Statement ................................................................................13

**CHAPTER 3: CONTACTS**

Overview ................................................................................................................15
UniCare Contacts ....................................................................................................15
State of West Virginia Contacts ............................................................................18

**CHAPTER 4: COVERED AND NONCOVERED SERVICES**

UniCare Covered Services .......................................................................................21
Benefits Matrix for UniCare ....................................................................................22
Dental Services ........................................................................................................25
Dental Services: Dental Screening and Referral for Children Ages 0 to under 21 ......25
Dental Services: Dental Coverage for Accidents or Emergencies .......................26
Vision Services .......................................................................................................26
Behavioral Health Services ....................................................................................27
Hospice Care ..........................................................................................................27
County and State-Linked Services .........................................................................27
Essential Public Health Services ...........................................................................28
Directly Observed Therapy .....................................................................................28
Reportable Diseases ...............................................................................................28
WIC Referrals .........................................................................................................29

**CHAPTER 5: MEMBER ELIGIBILITY**

Overview ................................................................................................................30
How to Verify Member Eligibility ..........................................................................30
Member Identification Cards ..................................................................................30

**CHAPTER 6: UTILIZATION MANAGEMENT**

Overview ................................................................................................................33
Services Requiring Prior Authorization ................................................................35
Services Not Requiring Prior Authorization ..........................................................35
UM or Prior Authorization Toolkit ..........................................................................36
Starting the Process ...............................................................................................37
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Claims and Billing</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Requesting Authorization</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Authorization Forms</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Requests with Insufficient Clinical Information</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Preservice Review Time Frame</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Urgent Preservice Requests</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Emergency Medical Conditions and Services</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Emergency Stabilization and Post-Stabilization</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Referrals to Specialists</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network Exceptions</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>Continued Stay Review: Hospital Inpatient Admissions</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>Continued Stay Review: Clinical Information for Continued Stay Review</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>Denial of Service</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>Self-Referral</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Second Opinions</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Additional Services: Behavioral Health</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Additional Services: Vision Care</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Additional Services: Dental Care</td>
<td>43</td>
</tr>
<tr>
<td>7</td>
<td>Health Services Programs</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Overview</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Healthy Rewards</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Preventive Care: Health Screenings and Immunizations</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>Preventive Care: Initial Health Assessments</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>Preventive Care: HealthCheck</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>Preventive Care: Childhood Lead Exposure Testing and Free Blood Test Kits</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Preventive Care: Well Woman</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Health Management: Taking Care of Baby and Me®</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Provider Assessment of Pregnancy Risk</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Breastfeeding Support Tools and Services</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Health Management: New Mother and Baby Post-Delivery Outreach Program</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Health Education: 24/7 NurseLine</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>Health Education: Emergency Room Action Campaign</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>Health Education: Weight Watchers Membership</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Health Education: Tobacco Cessation Programs</td>
<td>52</td>
</tr>
<tr>
<td>8</td>
<td>Overview</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Submitting Clean Claims</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>ICD-10</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Claims Filing Limits</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Claim Forms and Filing Limits</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>Other Filing Limits</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Methods for Submission</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>Electronic Claims</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>National Provider Identifier</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>Use of Referring Provider’s NPI on Claims Submissions</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>Unattested NPIs</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Paper Claims</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Paper Claims Processing</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Member Balance Billing</td>
<td>61</td>
</tr>
</tbody>
</table>
Overview.................................................................................................................................87

CHAPTER 10: BILLING INSTITUTIONAL CLAIMS ........................................................................87

Overview........................................................................................................................................87

CHAPTER 9: BILLING PROFESSIONAL AND ANCILLARY CLAIMS ........................................73

Overview........................................................................................................................................73

CHAPTER 8: CLAIMS INVESTIGATION ......................................................................................69

Overview........................................................................................................................................69

CHAPTER 7: CLAIMS REJECTION AND RETURN........................................................................67

Overview........................................................................................................................................67

CHAPTER 6: CLAIMS SUBMISSION ............................................................................................63

Overview........................................................................................................................................63

CHAPTER 5: PROFESSIONAL AND ANCILLARY CLAIMS ...........................................................59

Overview........................................................................................................................................59

CHAPTER 4: HOSPITAL CLAIMS ................................................................................................75

Overview........................................................................................................................................75

CHAPTER 3: BILLING AND CLAIMS PROCESSING .......................................................................71

Overview........................................................................................................................................71

CHAPTER 2: BILLING PROCEDURES ........................................................................................67

Overview........................................................................................................................................67

CHAPTER 1: INTRODUCTION .........................................................................................................63

Overview........................................................................................................................................63

Appendix A: Reference: Clinical Submission Categories..............................................................91

Overview........................................................................................................................................91

Appendix B: Reference: Common Reasons for Rejected and Returned Claims............................92

Overview........................................................................................................................................92

Appendix C: Reference: Benefit Codes............................................................................................93

Overview........................................................................................................................................93

Appendix D: Reference: Clinical Submission Categories..............................................................94

Overview........................................................................................................................................94

Appendix E: Reference: Common Reasons for Rejected and Returned Claims............................95

Overview........................................................................................................................................95

Appendix F: Reference: Benefit Codes............................................................................................96

Overview........................................................................................................................................96

Appendix G: Reference: Clinical Submission Categories..............................................................97

Overview........................................................................................................................................97

Appendix H: Reference: Common Reasons for Rejected and Returned Claims............................98

Overview........................................................................................................................................98

Appendix I: Reference: Benefit Codes............................................................................................99

Overview.........................................................................................................................................100

Appendix J: Reference: Clinical Submission Categories..............................................................100

Overview.........................................................................................................................................100

Appendix K: Reference: Common Reasons for Rejected and Returned Claims............................101

Overview.........................................................................................................................................101

Appendix L: Reference: Benefit Codes............................................................................................102

Overview.........................................................................................................................................102

Appendix M: Reference: Clinical Submission Categories..............................................................103

Overview.........................................................................................................................................103

Appendix N: Reference: Common Reasons for Rejected and Returned Claims............................104

Overview.........................................................................................................................................104

Appendix O: Reference: Benefit Codes............................................................................................105

Overview.........................................................................................................................................105

Appendix P: Reference: Clinical Submission Categories..............................................................106

Overview.........................................................................................................................................106

Appendix Q: Reference: Common Reasons for Rejected and Returned Claims............................107

Overview.........................................................................................................................................107

Appendix R: Reference: Benefit Codes............................................................................................108

Overview.........................................................................................................................................108

Appendix S: Reference: Clinical Submission Categories..............................................................109

Overview.........................................................................................................................................109

Appendix T: Reference: Common Reasons for Rejected and Returned Claims............................110

Overview.........................................................................................................................................110

Appendix U: Reference: Benefit Codes............................................................................................111

Overview.........................................................................................................................................111

Appendix V: Reference: Clinical Submission Categories..............................................................112

Overview.........................................................................................................................................112

Appendix W: Reference: Common Reasons for Rejected and Returned Claims............................113

Overview.........................................................................................................................................113

Appendix X: Reference: Benefit Codes............................................................................................114

Overview.........................................................................................................................................114

Appendix Y: Reference: Clinical Submission Categories..............................................................115

Overview.........................................................................................................................................115

Appendix Z: Reference: Common Reasons for Rejected and Returned Claims............................116

Overview.........................................................................................................................................116

Appendix AA: Reference: Benefit Codes...........................................................................................117

Overview.........................................................................................................................................117

Appendix BB: Reference: Clinical Submission Categories..............................................................118

Overview.........................................................................................................................................118

Appendix CC: Reference: Common Reasons for Rejected and Returned Claims............................119

Overview.........................................................................................................................................119

Appendix DD: Reference: Benefit Codes...........................................................................................120

Overview.......................................................................................................................................120

APPENDIX: REFERENCES ...............................................................................................................121

Overview.......................................................................................................................................121

APPENDIX: INDEX ..........................................................................................................................123

Overview.......................................................................................................................................123

INDEX ...............................................................................................................................................125

Overview.......................................................................................................................................125
Basic Billing Guidelines ................................................................. 88
National Drug Codes ................................................................. 88
Emergency Room Visits ............................................................ 89
Urgent Care Visits ................................................................. 90
Observation ............................................................................. 91
Maternity Services ................................................................. 91
Hysterectomy ............................................................................ 91
Sterilization .............................................................................. 92
Inpatient Acute Care ............................................................... 92
Billing for Hospital Stays of Less Than 24 Hours ...................... 93
Inpatient Subacute Care .......................................................... 93
Outpatient Laboratory, Radiology and Diagnostic Services .......... 94
Outpatient Surgical Services .................................................. 94
Outpatient Therapies .............................................................. 95
Outpatient Infusion Therapies and Pharmaceuticals ................. 95
Ancillary Billing Overview ....................................................... 96
Ambulance Services ............................................................... 96
Ambulatory Surgical Centers .................................................. 96
Physical Therapy ...................................................................... 96
Speech Therapy ....................................................................... 97
Occupational Therapy ........................................................... 97
Durable Medical Equipment ................................................... 97
Durable Medical Equipment: Rentals ...................................... 98
Durable Medical Equipment: Purchase .................................... 98
Durable Medical Equipment: Wheelchairs and Wheeled Mobility Aids 98
Dialysis .................................................................................... 99
Home Infusion Therapy .......................................................... 99
Laboratory and Diagnostic Imaging ......................................... 99
Home Health Care .................................................................. 99
Hospice ................................................................................... 99
Additional Billing Resources ................................................... 99
CMS-1450 Claim Form ............................................................. 100
CMS-1450 Revenue Codes ..................................................... 100
Institutional Inpatient Coding ................................................ 100
Institutional Outpatient Coding ............................................. 100
Recommended Fields for the CMS-1450 Claim Form ............... 100

CHAPTER 11: MEMBER TRANSFERS AND DISENROLLMENT .............................................. 103
  Member PCP Reassignments .................................................. 103
  PCP Initiated Member Reassignments ................................... 103
  State Agency-Initiated Member Disenrollment ....................... 104
  PCP-Initiated Member Disenrollment .................................... 104
  Member Initiated Disenrollment ........................................... 105
  Involuntary Member Disenrollment ....................................... 105

CHAPTER 12: GRIEVANCES AND APPEALS ................................................................. 106
  Overview ............................................................................... 106
  Providers: Grievances Relating to the Operation of the Plan .......... 107
  Providers: Grievance Response Timeline ............................... 108
  Providers: Claims Disputes and Payment Appeals .................. 108
CHAPTER 13: CREDENTIALING AND REcredentialing ................................................................. 116
Overview ................................................................................................................................. 116
Council for Affordable Quality Healthcare .............................................................................. 116
CAQH ProView Registration: First Time Users ...................................................................... 116
CAQH/ProView Registration: Completing the Application Process .................................. 117
CAQH/ProView Registration: Existing Users .......................................................................... 118
Additional CAQH Resources .................................................................................................. 118
UniCare Contracting Process for Hospital or Facility-Based Providers .............................. 118
Credentialing Updates ............................................................................................................ 119
Recredentialing ...................................................................................................................... 119
UniCare’s Discretion ............................................................................................................... 120
Credentialing Scope ............................................................................................................... 120
Credentialing Committee ...................................................................................................... 121
Nondiscrimination Policy ....................................................................................................... 123
Initial Credentialing ............................................................................................................... 123
Recredentialing ...................................................................................................................... 124
Health Delivery Organization ............................................................................................... 125
Ongoing Sanction Monitoring .............................................................................................. 125
Appeals Process ..................................................................................................................... 126
Reporting Requirements ....................................................................................................... 126
Credentialing Program Standards .......................................................................................... 127
CHAPTER 14: ACCESS STANDARDS AND ACCESS TO CARE .............................................. 139
Overview ................................................................................................................................. 139
General Appointment Scheduling ....................................................................................... 139
Services for Members ............................................................................................................ 140
Prenatal and Postpartum Visits ............................................................................................. 140
Missed Appointment Tracking ............................................................................................. 140
After-Hours Services ............................................................................................................ 141
Continuity of Care ................................................................................................................ 142
Provider Contract Termination ............................................................................................. 143
CHAPTER 18: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT ................................................................. 164

Overview ............................................................................................................................................... 164
Quality Improvement Program ............................................................................................................ 164
Healthcare Effectiveness Data and Information Set ............................................................................ 165
Practitioner/Provider Performance Data ............................................................................................ 165
Quality Management ......................................................................................................................... 166
Best Practice Methods .......................................................................................................................... 166
Member Satisfaction Surveys ............................................................................................................. 166
Provider Satisfaction Surveys ............................................................................................................. 167
Facility Site and Medical Record Reviews .......................................................................................... 167
Medical Record Documentation Standards ......................................................................................... 167
Medical Record Security ................................................................................................................... 167
Medical Record Storage and Maintenance ......................................................................................... 168
Availability of Medical Records ......................................................................................................... 168
Medical Record Requirements ........................................................................................................... 168
Misrouted Protected Health Information .......................................................................................... 169
Advance Directives ............................................................................................................................ 169
Medical Record Review Process ......................................................................................................... 170
Facility Site Review Process ................................................................................................................ 170
Facility Site Review: Corrective Actions .............................................................................................. 171
Preventable Adverse Events ................................................................................................................ 172
Practitioner/Provider Performance Data ............................................................................................ 172

CHAPTER 19: ENROLLMENT AND MARKETING RULES ....................................................................................... 174

Overview ............................................................................................................................................... 174
Marketing Policies ................................................................................................................................. 174
Enrollment Process ............................................................................................................................... 175
Enrolling Newborns .............................................................................................................................. 176

CHAPTER 20: FRAUD, ABUSE AND WASTE ........................................................................................................ 177

Reporting Fraud, Waste and Abuse ........................................................................................................ 178
Examples of Provider Fraud, Waste and Abuse: .................................................................................. 178
False Claims Act ................................................................................................................................. 180
HIPAA ................................................................................................................................................... 180

CHAPTER 21: MEMBER RIGHTS AND RESPONSIBILITIES ....................................................................................... 182

Overview ............................................................................................................................................... 182
Member Rights ..................................................................................................................................... 182
Member Responsibilities ....................................................................................................................... 183

CHAPTER 22: CULTURAL DIVERSITY AND LINGUISTIC SERVICES ........................................................................... 185

Overview ............................................................................................................................................... 185
Language Capability of Providers and Office Staff .............................................................................. 186
Interpreter Services ................................................................................................................................. 187
Americans with Disabilities Act ........................................................................................................... 187
CHAPTER 1: INTRODUCTION

Introduction

Welcome

Welcome and thank you for being part of the UniCare Health Plan of West Virginia, Inc. (UniCare) network.

UniCare has been selected by the state of West Virginia’s Bureau for Medical Services (BMS) to provide health care services for all counties in West Virginia. BMS manages the Mountain Health Trust and West Virginia Health Bridge Medicaid managed care programs for West Virginia and is administered by the Department of Health and Human Resources (DHHR).

At UniCare, we are proud of local staff who works to maximize health care services for our members. The health plan has local field representatives who link network providers, members and community agencies to UniCare resources. Staff is available to:

- Provide training for health care professionals and their staff regarding enrollment, covered benefits, managed care operations and linguistic services.
- Provide member support services, including health education referrals, event coordination and coordination of cultural and linguistic services.
- Coordinate access to community health education resources for breastfeeding, smoking cessation, diabetes and asthma, to name a few.

There is strength in numbers; UniCare’s health services programs, combined with those already available in the community, are designed to supplement providers’ treatment plans. Our programs also serve to improve our members’ overall health by informing, educating and encouraging self-care in the prevention, early detection and treatment of existing conditions and chronic disease.

Introduction

About This Manual

This provider manual is designed for physicians, hospitals and ancillary providers. Our goal is to create a useful reference guide for you and your office staff. We want to help you navigate our managed health care plan to find the most reliable, responsible, timely and cost-effective ways to deliver quality health care to our members.

We recognize that managing our members’ health can be a complex undertaking requiring familiarity with the rules and regulations of a complex health care system. This system encompasses a wide array of services and responsibilities (for example, initial health assessments (IHAs), case management, proper storage of medical records and billing for emergencies). With this complexity in mind, we divided this manual into sections that reflect your questions, concerns and responsibilities before and after a UniCare member walks through your doors. The sections are organized as follows:

- Legal Requirements
- Contact Numbers
- Before Rendering Services
- After Rendering Services
- Operational Standards, Requirements and Guidelines
- Additional Resources
**Introduction**

**Legal Requirements**
The information contained in this manual is proprietary, will be updated regularly and is subject to change. This section provides specific information on the legal obligations of being part of the UniCare network.

**Introduction**

**Contacts**
This section is your reference for important contact numbers, websites and mailing addresses.

**Introduction**

**Before Rendering Services**
This section provides the information and tools you will need before providing services, including *Member Eligibility* and a list of *Covered and Noncovered Services*. The section also includes a chapter on the prior authorization process and the coordination of complex care through our Utilization Management department.

We take pride in our proactive approach to health. The chapter on health services programs details how targeted programs can supplement your treatment plans to make the services you provide more effective. For example, the initial health assessment is our first step in providing preventive care. The emergency room action campaign is aimed at promoting proper use of emergency room services, and the health services programs under *Condition Management* take direct aim at combating the most common and serious conditions and illnesses facing our members, including obesity, cardiovascular disease, diabetes and asthma.

**Introduction**

**After Rendering Services**
At UniCare, our goal is to make the billing process as streamlined as possible. The *After Rendering Services* section provides guidelines and detailed coding charts for fast, secure and efficient billing and includes specific information about filing claims for professional and institutional services. In addition, the *Member Transfers* chapter outlines the steps for members who want to change their assignment of PCP or transfer to another health plan. When questions or concerns come up about claims or adverse determinations, our chapter on grievances and appeals will take you step-by-step through the process.

**Introduction**

**Operational Standards, Requirements and Guidelines**
This section summarizes the requirements for provider office operations and access standards, thereby ensuring consistency when members need to consult with providers for IHAs, referrals, coordination of care and follow-up care. Additional chapters detail provider credentialing, provider roles and responsibilities, and enrollment and marketing guidelines. Chapters on both clinical practice and preventive health guidelines and case management outline the steps providers should take to coordinate care and help members take a proactive stance in the fight against disease. And finally, we included a chapter documenting our commitment to participate in the quality assessments that help UniCare measure, compare and improve our standards of care.
Introduction

Additional Resources
To help providers serve a diverse and ever-evolving patient population, we designed a special program, Cultural Diversity and Linguistic Services, to improve provider/member communications by cutting through language and other cultural barriers. In addition, UniCare works with nationally-recognized health care organizations to stay current on the latest health care breakthroughs and discoveries. This manual provides easy links to access that information. We also provide forms and reference guides on a wide variety of subjects.

Introduction

Accessing Information, Forms and Tools on Our Website
A wide array of tools, information and forms are accessible via the Provider Resources page of our website at www.unicare.com. Throughout this manual, we will refer you to items located on the Provider Resources page. To access this page, please follow these steps:
1. Select OTHER UNICARE WEBSITES: Providers at the top of the screen.
2. In the Resources for section, select State Sponsored Plan providers.
3. Select West Virginia – Medicaid Managed Care.

To access a PDF of this provider manual online, scroll to the Provider Communications section and select Provider Manual and Important Updates > Provider Manual.

Introduction

Using the Provider Manual
Select any topic in the Table of Contents to view that chapter, and select any web address to be redirected to that site. Each chapter may contain cross-links to other chapters, to the UniCare website or to external websites containing additional information.

If you have any questions about the content of this manual, contact the Customer Care Center at 1-800-782-0095. Hours: Monday to Friday, 8 a.m. to 6 p.m.

Introduction

Websites
The UniCare website and this manual may contain links and references to internet sites owned and maintained by third-party sites. Neither UniCare nor its related affiliated companies operate or control, in any respect, any information, products or services on third-party sites. Such information, products, services and related materials are provided “as is” without warranties of any kind, either express or implied, to the fullest extent permitted under applicable laws. UniCare disclaims all warranties, express or implied, including, but not limited to, implied warranties of merchantability and fitness. UniCare does not warrant or make any representations regarding the use or results of the use of third-party materials in terms of their correctness, accuracy, timeliness, reliability or otherwise.
CHAPTER 2: LEGAL AND ADMINISTRATIVE REQUIREMENTS

Legal and Administrative Requirements

Proprietary Information
The information contained in this provider manual is proprietary. By accepting this manual, UniCare providers agree:

• To use this manual solely for the purposes of referencing information regarding the provision of medical services to UniCare members enrolled for services through UniCare
• To protect and hold the manual’s information as confidential
• Not to disclose the information contained in this manual

Legal and Administrative Requirements

Privacy Practices
UniCare’s latest HIPAA-compliant privacy and security statements may be found in the Notice of Privacy Practices. For more information, refer to the Policies, Manuals and Guidelines section on the Provider Resources page of our website at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Throughout this manual, there are instances where information is provided as a sample or example. This information is meant to illustrate and is not intended to be used or relied upon.

There are places within the manual where you may leave the UniCare site and link to another operated by a third party. These links are provided for your convenience and reference only. UniCare and its subsidiary companies do not control such sites and do not necessarily endorse these sites. UniCare is not responsible for their content, products or services.

Please be aware that when you link from the UniCare site to another site, you will be subject to the privacy policies (or lack thereof) of the other sites. UniCare cautions you to determine the privacy policy of such sites before providing any personal information.

Legal and Administrative Requirements

Misrouted Protected Health Information
Providers and facilities are required to review all member information received from UniCare to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice. Providers and facilities are required to destroy immediately any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please contact the Customer Care Center at 1-800-782-0095.

Legal and Administrative Requirements

Updates and Changes
The provider manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change. In the event of an inconsistency between information contained in
the manual and the provider agreement between you or your facility and UniCare, the provider agreement shall govern.

In the event of a material change to the Behavioral Health Provider Manual, we will make all reasonable efforts to notify you in advance of such change through web-posted newsletters, fax communications (such as provider bulletins) and other mailings. In such cases, the most recently published information should supersede all previous information and be considered the current directive. UniCare will notify providers of any material change at least 30 days before the intended effective date of the change.

The manual is not intended to be a complete statement of all UniCare policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially-targeted communications, as referenced above. This manual does not contain legal, tax or medical advice. Please consult your own advisors for such advice.

Legal and Administrative Requirements

Nondiscrimination Statement

UniCare does not engage in, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color or national origin in providing aid, benefits or services to beneficiaries. UniCare does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. UniCare does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of or subjecting them to discrimination on the basis of gender or gender identity. In addition, in compliance with the Age Act, UniCare may not discriminate against any person on the basis of age or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. UniCare provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a UniCare representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so if the member requests assistance. We document, track and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

UniCare provides free tools and services to people with disabilities to communicate effectively with us. UniCare also provides free language services to people whose primary language isn’t English (for example, qualified interpreters and information written in other languages). These services can be obtained by calling the Member Services number on their member ID card.
If you or your patient believe that UniCare has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with our member advocate via:

- Phone: **1-888-611-9958**
- Mail: 200 Association Drive, Suite 200, Charleston, WV 25311

**Equal Program Access on the Basis of Gender**

UniCare provides individuals with equal access to health programs and activities without discriminating on the basis of gender. UniCare must also treat individuals consistently with their gender identity and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (that is, race, color, national origin, gender, gender identity, age or disability).

UniCare may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.
CHAPTER 3: CONTACTS

Contacts
Overview
When you need the right phone number, fax number, website or street address, the information should be right at your fingertips. With that in mind, we have compiled the most-used contacts for you and your office staff. The first chart gives you contact information for UniCare. The second chart is contact information for the health services programs and management topics handled by West Virginia.

Contacts
UniCare Contacts

<table>
<thead>
<tr>
<th>Contact Information for UniCare</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have questions about...</strong></td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Note: For faster service, please indicate how you want the correspondence routed (e.g., “Attn: Initial Claims Department”).</td>
</tr>
<tr>
<td>Authorization</td>
</tr>
<tr>
<td>Availity</td>
</tr>
<tr>
<td>Behavioral health services</td>
</tr>
<tr>
<td>Benefits, eligibility, verifying PCP and general provider questions</td>
</tr>
<tr>
<td>Case Management referrals</td>
</tr>
<tr>
<td>If you have questions about...</td>
</tr>
<tr>
<td>-------------------------------</td>
</tr>
</tbody>
</table>
| Claims overpayment | Mail overpayment to: UniCare Health Plan of West Virginia, Inc. Attn: Overpayment Recovery P.O. Box 73651 Cleveland, OH 44193  
Address for overnight delivery: UniCare Health Plan of West Virginia, Inc. Attn: Overpayment Recovery Lockbox 92420 4100 West 150th St. Cleveland, OH 44135 |
| Customer care center | Hours: Monday to Friday, 8 a.m. to 6 p.m.  
Phone: **1-800-782-0095**  
TTY: **1-866-368-1634**  
Fax: **1-888-438-5209**  
After hours:  
Phone: **1-888-850-1108**  
TTY: **1-800-368-4424** |
| Dental services: Scion Dental | Member Information:  
Phone: **1-877-408-0917**  
TTY: **1-800-508-6975**  
Hours: 8 a.m. to 6 p.m.  
Website: [www.sciondental.com](http://www.sciondental.com)  
Provider Hotline:  
Phone: **1-877-724-6602**  
Adult emergent: **1-877-408-0881**  
Children Medicaid: **1-888-983-4686**  
Hours: Monday to Friday, 8 a.m. to 6 p.m. |
| Fraud and abuse | **Fraud Hotline**  
Phone: **1-855-315-8927**  
Hours: Monday to Friday, 8 a.m. to 6 p.m.  
Website: [www.unicare.com](http://www.unicare.com) |
| Grievances and appeals | For questions related to grievances or appeals, contact the Customer Care Center by phone: **1-800-782-0095**  
Hours: Monday to Friday, 8 a.m. to 6 p.m.  
Written correspondence: UniCare Health Plan of West Virginia, Inc. Attn: Grievance and Appeals Department P.O. Box 91 Charleston, WV 25321-0091 Fax: **1-866-387-2968** |
<table>
<thead>
<tr>
<th>If you have questions about...</th>
<th>Contact:</th>
</tr>
</thead>
</table>
| Interpreter services          | Customer Care Center  
  Phone: **1-800-782-0095**  
  Hours: Monday to Friday, 8 a.m. to 6 p.m.  
  After hours, call the 24/7 NurseLine: **1-888-850-1108**  
  For TTY and relay services during business hours, call UniCare's  
  Customer Care Center TTY line: **1-866-368-1634**  
  After hours, call the 24/7 NurseLine TTY line: **1-800-368-4424** |
| UniCare office               | To obtain UniCare staff contact information, contact your network  
  education representative:  
  Phone: **1-888-611-9958**  
  Fax: **1-888-338-1320**  
  Address:  
  UniCare Health Plan of West Virginia, Inc.  
  200 Association Drive, Suite 200  
  Charleston, WV 25311 |
| 24/7 NurseLine               | Phone: **1-888-850-1108**  
  TTY: **1-800-368-4424**  
  Hours: 24/7  
  Available after normal business hours to verify member eligibility. |
| Members with hearing or     | West Virginia Relay Service is a toll-free TDD service. Call **711** or the  
  speech loss               | following numbers:  
                          • For voice to TDD: **1-800-982-8772**  
                          • For TDD to voice: **1-800-982-8771**  
  Website: [www.westvirginiarelay.com](http://www.westvirginiarelay.com) |
| Pharmacy help desk (Molina) | Prescriber prior authorization:  
                          • Phone: **1-888-483-0801**  
                          • Fax: **1-800-531-7787** |
| Pharmacy preferred drug list | The PDL is part of the pharmacy service provided by BMS and is located  
  (PDL) inquiries           | on the BMS website at [www.dhhr.wv.gov/bms](http://www.dhhr.wv.gov/bms). In the Providers  
                          section, select Pharmacy. In the top navigation menu, select **Preferred Drug List**. Scroll to select the most recently posted version. |
| Physician-administered drugs | Phone: **1-877-375-6185**  
  (preauthorization)        | Fax: **1-844-487-9290** |
| Smoking Cessation Program   | For questions regarding this program, call the Customer Care Center:  
                          Phone: **1-800-782-0095**  
                          TTY: **1-866-368-1634**  
                          Hours: Monday to Friday, 8 a.m. to 6 p.m.  
  Materials available for download:  
                          • The "Quit Guide" Clearing the Air is available at the website: [smokefree.gov](http://smokefree.gov) |
<table>
<thead>
<tr>
<th>If you have questions about...</th>
<th>Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• National Cancer Institute phone (for ordering): 1-800-4-CANCER (1-800-422-6237). Website: <a href="https://pubs.cancer.gov">https://pubs.cancer.gov</a></td>
<td></td>
</tr>
<tr>
<td>Vision Services - Vision Service Plan (VSP)</td>
<td>Website: <a href="http://www.vsp.com">www.vsp.com</a></td>
</tr>
<tr>
<td>Contact information for members:</td>
<td></td>
</tr>
<tr>
<td>Phone: 1-800-877-7195</td>
<td></td>
</tr>
<tr>
<td>TTY: 1-800-428-4833</td>
<td></td>
</tr>
<tr>
<td>Hours: Monday to Friday, 8 a.m. to 11 p.m.; Saturday, 10 a.m. to 7 p.m.</td>
<td></td>
</tr>
<tr>
<td>Contact information for providers (claims and membership questions):</td>
<td></td>
</tr>
<tr>
<td>Phone: 1-800-615-1883</td>
<td></td>
</tr>
<tr>
<td>Hours: Monday to Friday, 8 a.m. to 11 p.m.; Saturday, 10 a.m. to 7 p.m.</td>
<td></td>
</tr>
<tr>
<td>Email: <a href="mailto:questions@vspglobal.com">questions@vspglobal.com</a></td>
<td></td>
</tr>
</tbody>
</table>

Contacts
State of West Virginia Contacts

<table>
<thead>
<tr>
<th>Contact Information for the State of West Virginia</th>
<th>Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have questions about...</td>
<td>Breastfeeding Education Coordinator, Office of Nutrition Services</td>
</tr>
<tr>
<td>Breastfeeding support</td>
<td>Phone: 1-304-558-0030</td>
</tr>
<tr>
<td></td>
<td>Website: <a href="https://www.wvdhhr.org/ons/breastfeeding.asp">https://www.wvdhhr.org/ons/breastfeeding.asp</a></td>
</tr>
<tr>
<td>Bureau for Behavioral Health and Health Facilities (BHHF)</td>
<td>BHHF manages behavioral health services and is administered by the DHHR.</td>
</tr>
<tr>
<td></td>
<td>Phone: 1-304-356-4811</td>
</tr>
<tr>
<td></td>
<td>Fax: 1-304-558-1008</td>
</tr>
<tr>
<td></td>
<td>Hours: Monday to Friday, 8:30 a.m. to 4:30 p.m.</td>
</tr>
<tr>
<td></td>
<td>Website: <a href="https://dhhr.wv.gov/bhhf">https://dhhr.wv.gov/bhhf</a></td>
</tr>
<tr>
<td>Bureau for Children and Families (BCF)</td>
<td>Phone: 1-304-558-0628</td>
</tr>
<tr>
<td></td>
<td>Website: <a href="https://dhhr.wv.gov/bcf">https://dhhr.wv.gov/bcf</a></td>
</tr>
<tr>
<td>Bureau for Medical Services</td>
<td>BMS manages the Medicaid program for West Virginia, administered by the DHHR.</td>
</tr>
<tr>
<td></td>
<td>Website: <a href="http://www.dhhr.wv.gov/bms">www.dhhr.wv.gov/bms</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 1-304-558-1700</td>
</tr>
<tr>
<td></td>
<td>Toll-free Medicaid Provider Services: 1-888-483-0793</td>
</tr>
<tr>
<td></td>
<td>Address:</td>
</tr>
<tr>
<td></td>
<td>Bureau for Medical Services</td>
</tr>
<tr>
<td></td>
<td>350 Capitol St., Room 251</td>
</tr>
<tr>
<td></td>
<td>Charleston, WV 25301</td>
</tr>
<tr>
<td>Bureau for Public Health</td>
<td>Website: <a href="http://www.dhhr.wv.gov/bph">www.dhhr.wv.gov/bph</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 1-304-558-2971</td>
</tr>
<tr>
<td>Children with Disabilities Community Services Program</td>
<td>Website: <a href="http://www.dhhr.wv.gov/bms/Programs/Pages/default.aspx">www.dhhr.wv.gov/bms/Programs/Pages/default.aspx</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 1-304-356-4904</td>
</tr>
<tr>
<td>Commission for the Deaf and Hard of Hearing</td>
<td>Phone: 1-304-558-1675</td>
</tr>
<tr>
<td></td>
<td>TTY (in West Virginia only) toll free: 1-866-461-3578</td>
</tr>
<tr>
<td>If you have questions about...</td>
<td>Contact:</td>
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</tr>
<tr>
<td></td>
<td>Fax: <strong>1-304-558-0937</strong></td>
</tr>
<tr>
<td></td>
<td>Website: <a href="https://www.wvdhhr.org/wvcdhh">https://www.wvdhhr.org/wvcdhh</a></td>
</tr>
<tr>
<td></td>
<td>Address: Commission for the Deaf and Hard of Hearing</td>
</tr>
<tr>
<td></td>
<td>405 Capitol St., Suite 800</td>
</tr>
<tr>
<td></td>
<td>Charleston, WV 25301</td>
</tr>
<tr>
<td>Department of Health and Human Resources</td>
<td>Phone: <strong>1-304-558-0684</strong></td>
</tr>
<tr>
<td></td>
<td>Fax: <strong>1-304-558-1130</strong></td>
</tr>
<tr>
<td></td>
<td>Website: <a href="https://dhhr.wv.gov/Pages/default.aspx">https://dhhr.wv.gov/Pages/default.aspx</a></td>
</tr>
<tr>
<td></td>
<td>Address: Department of Health and Human Resources</td>
</tr>
<tr>
<td></td>
<td>One Davis Square, Suite 100 East</td>
</tr>
<tr>
<td></td>
<td>Charleston, WV 25301</td>
</tr>
<tr>
<td>Division of Rehabilitative Services (DRS)</td>
<td>Website: <a href="http://www.wvdrs.org">www.wvdrs.org</a></td>
</tr>
<tr>
<td>Enrollment</td>
<td>In person: Visit your local Department of Health and Human Resources (DHR) office. To locate your local office, go to: <a href="https://dhhr.wv.gov/bcf/Documents/DHHR.BCF.LocalOffices.pdf">https://dhhr.wv.gov/bcf/Documents/DHHR.BCF.LocalOffices.pdf</a></td>
</tr>
<tr>
<td></td>
<td>Phone: Call the enrollment broker at <strong>1-800-449-8466</strong>.</td>
</tr>
<tr>
<td></td>
<td>Website: <a href="http://www.wvinroads.org">www.wvinroads.org</a></td>
</tr>
<tr>
<td>Grievances and appeals: state fair hearing; board of review</td>
<td>State fair hearings website: <a href="https://dhhr.wv.gov/bcf">https://dhhr.wv.gov/bcf</a> Phone: <strong>1-800-642-8589</strong></td>
</tr>
<tr>
<td>Hearing or Speech Loss: West Virginia Relay Service</td>
<td>West Virginia Relay Service is a toll-free TDD service. Call 711 or the following numbers:</td>
</tr>
<tr>
<td></td>
<td>• For voice to TDD: <strong>1-800-982-8772</strong></td>
</tr>
<tr>
<td></td>
<td>• For TDD to voice: <strong>1-800-982-8771</strong></td>
</tr>
<tr>
<td></td>
<td>Website: <a href="http://www.westvirginiarelay.com">www.westvirginiarelay.com</a></td>
</tr>
<tr>
<td>Home health through BMS</td>
<td>Website: <a href="https://www.dhhr.wv.gov/bms/Programs/Pages/default.aspx">www.dhhr.wv.gov/bms/Programs/Pages/default.aspx</a> Phone: <strong>1-304-356-4840</strong></td>
</tr>
<tr>
<td></td>
<td>Address: Bureau for Medical Services</td>
</tr>
<tr>
<td></td>
<td>Program Manager, Home Health Services</td>
</tr>
<tr>
<td></td>
<td>350 Capitol St., Room 251</td>
</tr>
<tr>
<td></td>
<td>Charleston, WV 25301</td>
</tr>
<tr>
<td>Hospice services through BMS</td>
<td>Website: <a href="https://www.dhhr.wv.gov/bms/Programs/Pages/default.aspx">www.dhhr.wv.gov/bms/Programs/Pages/default.aspx</a> Phone: <strong>1-304-356-4840</strong></td>
</tr>
<tr>
<td></td>
<td>Address: Bureau for Medical Services</td>
</tr>
<tr>
<td>If you have questions about...</td>
<td>Contact:</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------</td>
</tr>
</tbody>
</table>
|                              | Program Manager, Hospice Services  
|                              | 350 Capitol St., Room 251  
|                              | Charleston, WV 25301 |
| Office of Home and Community Based Services | Website: [www.dhhr.wv.gov/bms/Programs/Pages/default.aspx](http://www.dhhr.wv.gov/bms/Programs/Pages/default.aspx)  
|                              | To contact, call BMS: **1-304-356-4904** |
| Personal care through BMS | Website: [www.dhhr.wv.gov/bms/Programs/Pages/default.aspx](http://www.dhhr.wv.gov/bms/Programs/Pages/default.aspx)  
|                              | To contact, call BMS: **1-304-558-1700** |
| Private duty nursing through BMS | Website: [www.dhhr.wv.gov/bms/Programs/Pages/default.aspx](http://www.dhhr.wv.gov/bms/Programs/Pages/default.aspx)  
|                              | Phone: **1-304-356-4840**  
|                              | Address:  
|                              | Program Manager, Private Duty Nursing Services  
|                              | Bureau for Medical Services  
|                              | 350 Capitol St., Room 251  
|                              | Charleston, WV 25301 |
| West Virginia HealthCheck through Early and Periodic Screening, Diagnosis and Treatment (EPSDT) | Phone: **1-800-642-9704**  
|                              | Website: [www.dhhr.wv.gov/healthcheck](http://www.dhhr.wv.gov/healthcheck) |
| West Virginia Women, Infants and Children (WIC) | Phone: **1-304-558-0030**  
|                              | Fax: **1-304-558-1541**  
|                              | Website: [http://ons.wvdhhr.org](http://ons.wvdhhr.org)  
|                              | Email: dhhrwic@wv.gov  
|                              | Address:  
|                              | Office of Nutrition Services  
|                              | West Virginia WIC Program  
|                              | 350 Capitol St., Room 519  
|                              | Charleston, WV 25301-3715 |
CHAPTER 4: COVERED AND NONCOVERED SERVICES

UniCare
Customer Care Center phone: 1-800-782-0095
Customer Care Center fax: 1-888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.
Website: www.unicare.com

UniCare Provider-Administered Drug Authorizations
Phone: 1-877-375-6185
Fax: 1-844-487-9290

Dental services: Scion Dental
Phone: 1-877-724-6602
Hours: Monday to Friday, 8 a.m. to 8 p.m.
Website: www.sciondental.com

Vision services: Vision Service Plan (VSP)
Phone: 1-866-615-1883
Hours: Monday to Friday, 11 a.m. to 8 p.m.
Website: www.vsp.com

Covered and Noncovered Services

UniCare Covered Services
Covered services include, but are not limited to:

• Ambulance (emergency only; nonemergency transport is covered by BMS)
• Behavioral Health services
• Chiropractic (subject to limits)
• Clinic services: general clinics, birthing centers, lab and radiology centers, health department clinics, rural health clinics (RHCs), federally qualified health centers (FQHCs)
• Dental services for adults (emergency only)
• Dental services for children (covered by Scion dental)
• Durable medical equipment (DME), supplies, and prosthetic devices
• Early and Periodic Screening, Diagnostic and Treatment (EPSDT): covers hearing, vision, dental, nutritional needs, health care treatment, routine shots/immunizations and lab tests for children under 21 years of age; also referred to as West Virginia HealthCheck
• Family planning services and supplies
• Handicapped children’s services/children with special health care needs services
• Home health care services
• Hospice
• Hospital services: inpatient and outpatient
• Lab and radiology (not received in a hospital; also includes services received for substance abuse treatment)
• Nurse practitioner services
• Physical or occupational therapy, speech pathology and audiology (subject to limits)
• Physician (doctor) services (includes services received for substance abuse treatment. Also includes fluoride varnish services, applicable to members aged 6 months to 3 years)
• Podiatry services (foot care)
• Pregnancy and maternity care
• Private duty/skilled nursing services (limited to members under the age of 21)
• School-based services (physical therapy, speech therapy, occupational therapy, nursing care agency or audiology. Limited to members under the age of 21. Refer to the West Virginia fee-for-service provider manual for service limitations.)
• Transportation (emergency only)
• Vision services

For coverage specifics, please refer to the BMS fee schedules located at www.dhhr.wv.gov/bms/FEES/Pages/default.aspx.

West Virginia Medicaid provides the following fee-for-service programs:
• Nonemergency medical transportation
• Long-term care/nursing home services
• Pharmacy coverage
• Abortion
• Personal care services
• Birth to Three services
• ICF/MR-Intermediate Care Facility for the Mentally Retarded
• Organ and tissue transplant services (except corneal transplants, which are covered by UniCare)

Covered and Noncovered Services
Benefits Matrix for UniCare
For a comprehensive list of covered services, access the benefit matrix documents located on our Provider Resources page on www.unicare.com. Scroll to the Forms and Tools section and select Benefit Matrix for Children, Benefit Matrix for Adults, or the Behavioral Health Benefit Matrix. These benefit matrices provide the differences in benefits between the Mountain Health Trust and West Virginia Health Bridge programs. These documents change when the state updates contracts; keep this page bookmarked for easy access to the most current information. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

The following provides a summary of the benefits offered through the Mountain Health Trust and West Virginia Health Bridge Programs:

Mountain Health Trust Benefits Summary

<table>
<thead>
<tr>
<th>Children (0 to 20 years )</th>
<th>Adults (21 years and older)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance (emergency only)</td>
<td>Ambulance (emergency only)</td>
</tr>
<tr>
<td>Ambulatory surgical center services</td>
<td>Ambulatory surgical center services</td>
</tr>
<tr>
<td>Behavioral health rehabilitation</td>
<td>Behavioral health rehabilitation</td>
</tr>
<tr>
<td>• Residential treatment</td>
<td>• Residential treatment</td>
</tr>
<tr>
<td>Cardiac and pulmonary rehabilitation</td>
<td>Cardiac and pulmonary rehabilitation</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Chiropractic services</td>
</tr>
<tr>
<td>• Orthodontics</td>
<td>• Orthodontics</td>
</tr>
<tr>
<td>Dental services</td>
<td>Dental services (emergency treatment)</td>
</tr>
<tr>
<td>• Orthodontics</td>
<td>• Orthodontics</td>
</tr>
<tr>
<td>Diabetes management</td>
<td>Diabetes management</td>
</tr>
<tr>
<td>durable medical equipment</td>
<td>durable medical equipment</td>
</tr>
<tr>
<td>• Orthotics and prosthetics</td>
<td>• Orthotics and prosthetics</td>
</tr>
<tr>
<td>Children (0 to 20 years)</td>
<td>Adults (21 years and older)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>EPSDT (Well-child visits)</td>
<td>Family planning services and supplies</td>
</tr>
<tr>
<td>Family planning services and supplies</td>
<td>Family planning services and supplies</td>
</tr>
<tr>
<td>• Right From the Start Services</td>
<td>• Right From the Start Services</td>
</tr>
<tr>
<td>Hearing services</td>
<td></td>
</tr>
<tr>
<td>Home health including skilled nursing</td>
<td>Home health including skilled nursing</td>
</tr>
<tr>
<td>Hospice</td>
<td>Hospice</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>Inpatient services</td>
</tr>
<tr>
<td>• Inpatient hospital care</td>
<td>• Inpatient hospital care</td>
</tr>
<tr>
<td>• Inpatient rehabilitation</td>
<td>• Inpatient behavioral health and substance abuse</td>
</tr>
<tr>
<td>• Inpatient behavioral health and substance abuse</td>
<td></td>
</tr>
<tr>
<td>• Inpatient psychiatric services</td>
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<tr>
<td>Outpatient services</td>
<td>Outpatient services</td>
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<tr>
<td>• Diagnostic X-ray, laboratory services and testing</td>
<td>• Diagnostic X-ray, laboratory services and testing</td>
</tr>
<tr>
<td>• Physical therapy</td>
<td>• Physical therapy</td>
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<tr>
<td>• Speech therapy</td>
<td>• Speech therapy</td>
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<tr>
<td>• Occupational therapy</td>
<td>• Occupational therapy</td>
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<tr>
<td>• Behavioral health</td>
<td>• Behavioral health</td>
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<td></td>
<td>Participating providers may render up to 20 therapy visits to an eligible Mountain Health Trust member or 30 visits to an eligible West Virginia Health Bridge member without prior authorization. Beginning with the 21st or 31st visit, prior authorization is required to continue treatment. The limit excludes evaluation and re-evaluation and occurs over a 12-month rolling period. A visit may include any combination of physical/occupational therapy procedures performed on the same day.</td>
</tr>
<tr>
<td>Physician/nurse practitioner (NP)/nurse midwife (NMW)/federally qualified health center (FQHC)/rural health center (RHC) services</td>
<td>Physician/NP/NMW/FQHC/RHC services</td>
</tr>
<tr>
<td>• Primary/preventive care visits</td>
<td>• Primary/preventive care visits</td>
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<tr>
<td>• Physician office visits</td>
<td>• Physician office visits</td>
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<tr>
<td>• Specialty care</td>
<td>• Specialty care</td>
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<tr>
<td>• Podiatry</td>
<td>• Podiatry</td>
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<tr>
<td>Private duty nursing</td>
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<tr>
<td>Provider-administered medications</td>
<td>Provider-administered medications</td>
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<tr>
<td>Psychological Services</td>
<td>Psychological Services</td>
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<tr>
<td>Vision</td>
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<td></td>
<td>The services below are covered through Medicaid, but are not provided through the health plan. For information on how to use these services, look at the section of the handbook that explains what Medicaid covers.</td>
</tr>
<tr>
<td>Outpatient pharmacy medications</td>
<td>Outpatient pharmacy medications</td>
</tr>
<tr>
<td>Children (0 to 20 years)</td>
<td>Adults (21 years and older)</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Nonemergency transportation</td>
<td>Nonemergency transportation</td>
</tr>
<tr>
<td>Nursing home services</td>
<td>Nursing home services</td>
</tr>
<tr>
<td>Abortion</td>
<td>Abortion</td>
</tr>
<tr>
<td>Hemophilia factors</td>
<td>Hemophilia factors</td>
</tr>
<tr>
<td>Hepatitis drugs</td>
<td>Hepatitis drugs</td>
</tr>
<tr>
<td>Personal care services</td>
<td>Personal care services</td>
</tr>
<tr>
<td>School-based services</td>
<td></td>
</tr>
<tr>
<td>Transplants (except corneal transplants, which are covered by UniCare)</td>
<td>Transplants (except corneal transplants, which are covered by UniCare)</td>
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</table>

### West Virginia Health Bridge Benefit Summary

<table>
<thead>
<tr>
<th>Children (Age 1920 years)</th>
<th>Adults (21 years and older)</th>
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</thead>
<tbody>
<tr>
<td>Ambulance (emergency only)</td>
<td>Ambulance (emergency only)</td>
</tr>
<tr>
<td>Ambulatory surgical center services</td>
<td>Ambulatory surgical center services</td>
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<tr>
<td>Behavioral health rehabilitation</td>
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<tr>
<td>• Residential treatment</td>
<td></td>
</tr>
<tr>
<td>Cardiac and pulmonary rehabilitation</td>
<td>Cardiac and pulmonary rehabilitation</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Chiropractic services</td>
</tr>
<tr>
<td>Dental services</td>
<td>Dental services (emergency treatment)</td>
</tr>
<tr>
<td>Diabetes management</td>
<td>Diabetes management</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>Durable medical equipment</td>
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<tr>
<td>• Orthotics and prosthetics</td>
<td>• Orthotics and prosthetics</td>
</tr>
<tr>
<td>EPSDT (Well-child visits)</td>
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<tr>
<td>Family planning services and supplies</td>
<td>Family planning services and supplies</td>
</tr>
<tr>
<td>• Right From the Start Services</td>
<td>• Right From the Start Services</td>
</tr>
<tr>
<td>Hearing</td>
<td>Hearing</td>
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<tr>
<td>Home health including skilled nursing</td>
<td>Home health including skilled nursing</td>
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<tr>
<td>Hospice</td>
<td>Hospice</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>Inpatient services</td>
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<tr>
<td>• Inpatient hospital care</td>
<td>• Inpatient hospital care</td>
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<tr>
<td>• Inpatient rehabilitation</td>
<td>• Inpatient rehabilitation</td>
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<tr>
<td>• Inpatient behavioral health and substance abuse</td>
<td>• Inpatient behavioral health and substance abuse</td>
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<tr>
<td>• Inpatient psychiatric services</td>
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</tr>
<tr>
<td>Psychological Services</td>
<td>Psychological Services</td>
</tr>
<tr>
<td>Tobacco cessation</td>
<td>Tobacco cessation</td>
</tr>
<tr>
<td>Vision</td>
<td>Vision services (medical treatment only)</td>
</tr>
</tbody>
</table>

The services below are covered through Medicaid, but are not provided through your plan. For information on how to use these services, look at the section of the handbook that explains what Medicaid covers.

<table>
<thead>
<tr>
<th>Covered and Noncovered Services</th>
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</thead>
<tbody>
<tr>
<td><strong>Dental Services</strong></td>
</tr>
<tr>
<td>UniCare has contracted with Scion Dental to provide fee-for-service dental services for children under the age of 21. The West Virginia Bureau for Medical Services (BMS) is not responsible for payment of covered services. Scion Dental can be contacted as follows:</td>
</tr>
<tr>
<td>Phone: <strong>1-877-724-6602</strong></td>
</tr>
<tr>
<td>Hours: Monday to Friday, 8 a.m.-8 p.m.</td>
</tr>
<tr>
<td>Website: <a href="http://www.sciondental.com">www.sciondental.com</a></td>
</tr>
</tbody>
</table>

For adults age 21 and over, UniCare covers emergency dental services only, provided through Scion Dental.

<table>
<thead>
<tr>
<th>Covered and Noncovered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Services: Dental Screening and Referral for Children Ages 0 to under 21</strong></td>
</tr>
<tr>
<td>For children ages 0 to under 21, services are covered and provided through Scion Dental. Children ages 0 to under 21 years of age are eligible for the following:</td>
</tr>
<tr>
<td>• Covered diagnostic</td>
</tr>
<tr>
<td>• Preventive</td>
</tr>
<tr>
<td>• Restorative</td>
</tr>
<tr>
<td>• Periodontics</td>
</tr>
<tr>
<td>• Prosthodontics</td>
</tr>
<tr>
<td>• Maxillofacial prosthetics</td>
</tr>
<tr>
<td>• Oral and maxillofacial surgery/services</td>
</tr>
<tr>
<td>• Orthodontics, for the entire duration of treatment</td>
</tr>
</tbody>
</table>

Prior authorization may apply.
PCPs perform dental screenings as part of the initial health assessments (IHAs) for children. This inspection follows guidelines established under the U.S. Preventive Task Force Guidelines. Referrals to a dentist will occur following the IHA for children and when determined to be medically necessary. Refer parents needing assistance with scheduling dental appointments to West Virginia’s HealthCheck program, also known as the EPSDT program.

PCPs may receive a reimbursement for fluoride varnish application. Providers must complete a certified training course from the WVU School of Dentistry prior to performing and billing UniCare for these services. Phone: 1-800-642-9704 Website: www.dhhr.wv.gov/healthcheck

For adults age 21 and older, only emergency services are covered and are provided through Scion Dental. Refer to the Dental Services: Dental Coverage for Accidents or Emergencies section in this chapter for details.

Covered and Noncovered Services

Dental Services: Dental Coverage for Accidents or Emergencies
Dental services following an accident or emergency are covered under UniCare and are provided by Scion Dental. Emergency dental services are provided when a member has an accident and the dental work required is the initial repair of an injury to the jaw, sound natural teeth, mouth or face. The following services are covered by a dentist or oral surgeon:
- Treatment of fractures of the upper or lower jaw
- Biopsy
- Removal of tumors
- Removal of a tooth when it is an emergency

Limit: TMJ surgery and treatment are not covered for adults.

Covered and Noncovered Services

Vision Services
UniCare members under the age of 21 are eligible for vision services rendered by the following providers:
- Ophthalmologists
- Optometrists
- Opticians
- Surgeons

Covered services include the following:
- Eye surgery (not cosmetic)
- Eye examination for children (1 exam every 12 months)
- Lenses and frames every 12 months
- Repairs
- Glasses (first pair after cataract surgery)
- Contact lenses for certain diagnoses

Limits:
- Adult services are limited to medical treatment only.
- Prescription sunglasses and designer frames are not covered.
Covered and Noncovered Services

Behavioral Health Services

Behavioral health services are an integral part of health care management at UniCare. Our goal is to coordinate the physical and behavioral health care of members by offering a wide range of targeted interventions, education and enhanced access to care to ensure improved outcomes and quality of life for members.

UniCare establishes collegial relationships with treatment service providers such as hospitals, group practices and independent behavioral health care providers, as well as community agencies and West Virginia comprehensive community behavioral health centers, licensed behavioral health clinics and other resources to successfully meet the needs of members with behavioral health and substance use issues.

Behavioral health providers can be accessed directly by members and UniCare does not provide triage and referral services. Members do not have to contact UniCare for a referral.

UniCare has developed a supplemental *Behavioral Health Provider Manual*, developed specifically for behavioral health providers, available at [www.unicare.com](http://www.unicare.com).

Covered and Noncovered Services

Hospice Care

Hospice care is a covered service and must be preauthorized. Note the following guidelines:

- Providers must contact the UM department for authorization prior to hospice admission.
- The hospice should bill for hospice services on the CMS-1450 claim form.
- The *Hospice Care* section of the *West Virginia Provider Manual* provides detailed billing instructions. For more information, access the Bureau for Medical Services (BMS) website at [www.dhhr.wv.gov/bms](http://www.dhhr.wv.gov/bms). In the *Providers* section, click *Provider Manual*.

Covered and Noncovered Services

County and State-Linked Services

To ensure continuity and coordination of care for our members, UniCare enters into agreements with locally based public health programs. Providers are responsible for notifying UniCare’s Case Management department when a referral is made to any of the West Virginia agencies listed below:

- Bureau for Behavioral Health and Health Facilities: [www.dhhr.wv.gov/bhhf](http://www.dhhr.wv.gov/bhhf). Provides services for persons with mental illness, chemical dependency and developmental disabilities for reintegration into the community.
- Division of Local Health: [www.dhhr.wv.gov/localhealth](http://www.dhhr.wv.gov/localhealth). Serves as the state liaison to local health departments.
- Division of Rehabilitative Services (DRS): [www.wvdrs.org](http://www.wvdrs.org). Provides independence through in-home services, supported employment, independent living, nutrition, services for members with hearing loss, blindness or visual impairment and social security disability eligibility.
- Bureau for Children and Families (BCF): [https://dhhr.wv.gov/bcf/Pages/default.aspx](https://dhhr.wv.gov/bcf/Pages/default.aspx). BCF is a non-Medicaid program administered by the West Virginia Department of Health and Human Resources (DHHR) that provides a number of different programs for children and their families, including protective services, financial assistance and food stamps. Phone: **1-800-642-8589**

UniCare Case Management phone: **1-304-347-2475**
UniCare Case Management email: wvcmreferrals@anthem.com

Notifying Case Management ensures that case manager nurses and social workers can follow up with members to coordinate their care. This notification also ensures that members receive all necessary services while keeping the provider informed.

**Covered and Noncovered Services**

**Essential Public Health Services**
UniCare collaborates with public health entities in all service areas to ensure essential public health services for members. Services include the following:

- Coordination and follow-up of suspected or confirmed cases of childhood lead exposure
- Ensuring appropriate public health reporting (communicable diseases and/or diseases preventable by immunization)
- Investigation, evaluation and preventive treatment of persons with whom the member has come into contact
- Notification and referral of communicable disease outbreaks involving members; UniCare provides written notification to all participating providers regarding their responsibilities.
- Referral for tuberculosis and/or sexually transmitted infections or HIV contact
- Referral for Women, Infants, and Children (WIC) services and information sharing

**Covered and Noncovered Services**

**Directly Observed Therapy**
Tuberculosis (TB) has re-emerged as an important public health problem at the same time as drug resistance to the disease continues to rise. In large part, this resistance can be traced to poor compliance with medical regimens. In directly observed therapy (DOT), the member receives assistance in taking medications prescribed to treat TB. Refer members with TB who show evidence of poor compliance to the local health department for DOT services.

**Covered and Noncovered Services**

**Reportable Diseases**
By state mandate, providers must report communicable diseases and conditions to local health departments. UniCare’s providers are to comply with all state laws in the reporting of communicable diseases and conditions. Timely reporting is vital to minimize outbreaks and prevalence. Reportable diseases include, but are not limited to, the following primary types of diseases: sexually transmitted infections (STIs), TB and communicable diseases (for example, HIV, AIDS, etc.). UniCare attests annually that we have provided written notification to participating providers about your responsibility to and procedures for reporting these primary types of diseases to the state.

Division of Surveillance and Disease Control Reporting Health care practitioners and providers are required to report certain diseases by state law. This is to allow for disease surveillance and appropriate case investigation/public follow-up. The three primary types of diseases that must be reported are:

Sexually Transmitted Disease Program: Per WV Statute Chapter 16-4-6 and Legislative Rules Title 64, Series 7, practitioners and providers must report cases involving a sexually transmitted disease to the Division of Surveillance and Disease Control.
Tuberculosis Program: Per WV Statute Chapter 26-5A-4 and WV Regulations 16-25-3, practitioners and providers must report individuals with diseases caused by M. tuberculosis to the WV Bureau for Public, DSDC, and TB Program.

Communicable Disease Program: Per WV Legislative Rules Title 6-4, Series 7, practitioners and providers must report cases of communicable disease noted as reportable in West Virginia to the local health departments in the appropriate time frame and method outlined in legislative rules. Per legislative rule, reports of category IV diseases, including HIV and AIDS, are to be submitted directly to the State Health Department, not to local jurisdictions.

**Covered and Noncovered Services**

**WIC Referrals**
The WIC program provides healthy food to pregnant women and mothers of young children. Providers have the following responsibilities for WIC program referrals:

- Complete the *WIC Program Referral Form*, documenting the following information:
  - Anthropometric data (height, current weight, pregravid weight)
  - Any current medical conditions
  - Biochemical data (hemoglobin, hematocrit)
  - Expected date of delivery
- Provide the member with the completed referral form. The member then presents the referral form to the local WIC agency.

The *WIC Program Referral Form* may be found on the state’s website at [https://ons.wvdhhr.org](https://ons.wvdhhr.org)

West Virginia WIC phone: 1-304-558-0030
CHAPTER 5: MEMBER ELIGIBILITY

Customer Care Center phone: 1-800-782-0095
Customer Care Center fax: 1-888-438-5209
Hours of Operation: Monday to Friday, 8 a.m. to 6 p.m.
Website: www.unicare.com

Member Eligibility
Overview
Given the increasing complexities of health care administration, widespread potential for fraud and abuse, and constant fluctuations in program membership, providers need to be vigilant about member eligibility. This may mean taking extra steps to verify that any patient is, in fact, a currently-enrolled UniCare member.

To prevent fraud and abuse, providers should confirm the identity of the person presenting the ID card. Providers must verify a member’s eligibility before services are rendered. Verify eligibility at every visit because eligibility can change. Remember that claims submitted for services rendered to noneligible members will not be eligible for payment.

Member Eligibility
How to Verify Member Eligibility
The West Virginia Bureau for Medical Services (BMS) determines eligibility and enrollment for Medicaid Managed Care members. Providers can verify Medicaid Managed Care eligibility, including vision services, in the following ways:

- Log on to Availity at https://www.availity.com using your user ID and password or select Register. To register, you will need your federal TIN, organizational name and NPI.
- Call UniCare’s interactive voice response (IVR) system at 1-800-782-0095. The IVR system is available 24 hours a day, 7 days a week. When asked to enter your provider identification, use either your billing NPI number or your TIN.
- Call the BMS automated voice response (AVR) at 1-888-483-0793.

Member Eligibility
Member Identification Cards
Following enrollment, eligible enrollees will receive both their UniCare-issued member ID Card and state-issued Medicaid Managed Care member ID card.

UniCare-Issued Member Identification Card
The member ID card issued by UniCare authorizes medical services to be provided to UniCare members; however, this does not guarantee payment for services rendered. This plastic ID card is retained by members as long as they are managed by the same PCP. The ID card includes the following information:

- Member name
- Member ID number
- Coverage code
- Effective date
- PCP name and address
- Contact numbers: UniCare Customer Care Center, 24/7 NurseLine, vision, dental, eligibility, preapproval/hospital admissions
• Address for medical claim submission

If a card is lost, members may receive replacement cards upon request through our Customer Care Center or the member website. If the member transfers to a new PCP, UniCare issues a new ID card or the member can print a new card by logging in to the member website.

Please note: At each member visit, providers must ask to see the member’s ID card. Verify eligibility before rendering services and before submission of claims to UniCare.

State-Issued Medicaid Managed Care Member ID Card
Below are samples of state-issued member ID cards:

West Virginia Mountain Health Trust

Front of card

![West Virginia Mountain Health Trust Card Front Sample](image1)

Back of card

![West Virginia Mountain Health Trust Card Back Sample](image2)

West Virginia Health Bridge

Front of card

![West Virginia Health Bridge Card Front Sample](image3)
Back of card
CHAPTER 6: UTILIZATION MANAGEMENT

Utilization Management phone: 1-866-655-7423
Utilization Management fax: 1-855-402-6983 (preservice reviews) or 1-855-402-6985 (current inpatient reviews)
Availity Portal: https://www.availity.com
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Please note: UniCare ensures availability of Utilization Management (UM) department staff at least eight hours per day during normal business hours to answer and return UM-related calls.

Utilization Management
Overview
Utilization management is a cooperative effort with providers to promote, provide and document the appropriate use of health care resources. Our goal is to provide the right care, to the right member, at the right time, in the appropriate setting. UniCare makes determinations that consider the individual’s health care needs and medical history in conjunction with criteria.

The UM department takes a multidisciplinary approach to meet the medical and psychosocial needs of our members. UniCare’s decision-making process reflects the most up-to-date UM standards from the National Committee for Quality Assurance (NCQA). Authorizations are based on the following:

- Benefit coverage
- Established criteria
- Community standards of care

The decision-making criteria used by the UM department is evidence-based and consensus-driven. We update criteria at least annually and as standards of practice and technology change. We involve practicing physicians in these updates and then notify providers of changes through web-posted newsletters, fax communications (such as provider bulletins) and other mailings. These criteria are available to members and providers upon request by contacting the UM department at 1-866-655-7423. Hours: Monday to Friday, 8 a.m. to 5 p.m. Criteria are also available online at www.unicare.com.

If a member has other health insurance, UniCare defers all UM decisions to the primary insurer. If the primary insurance denies the request or the requested service is not covered under the primary plan, you can submit the denial or notice of noncoverage with the request to UniCare.

Based on sound clinical evidence, the UM department provides the following service reviews:

- Prior authorizations
- Continued stay reviews
- Post-service clinical claims reviews

Decisions affecting the coverage or payment for services are made in a fair, impartial, consistent and timely manner. The decision-making process incorporates nationally-recognized standards of care and practice from sources, including:

- American College of Cardiology
- American College of Obstetricians and Gynecologists
- American Academy of Pediatrics
- American Academy of Orthopedic Surgeons
• Cumulative professional expertise and experience
After a case is reviewed, decisions and notification time frames will be given for service:
• Approval
• Modification
• Denial

Please note: Our UM decisions are based only on appropriateness of care and service and existence of coverage. We do not reward practitioners and other individuals conducting utilization reviews for issuing denials of coverage or care. There are no financial incentives for UM decision-makers that encourage decisions resulting in under-utilization.

UniCare requires prior authorization of all elective inpatient admissions. The referring physician identifies the need to schedule a hospital admission and must submit the request to the UniCare Utilization Management (UM) department.

Routine requests for scheduled, elective admissions should be submitted at least 7 days prior to the scheduled admission. Urgent requests for admission with all supporting documentation must be submitted a minimum of 2 business days prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial.

Administrative denial: a denial of services based on reasons other than medical necessity

Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of prior authorization or failure by the provider to submit clinical information when requested. Appeals for administrative denials must address the reason for the denial (that is, why prior authorization was not obtained or why clinical information was not submitted). If UniCare overturns its administrative decision, the case will be reviewed for medical necessity. If approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken. This allows UniCare to verify benefits and process the prior authorization request. For services that require prior authorization, UniCare makes case-by-case determinations that consider the individual’s health care needs and medical histories in conjunction with criteria.

Generally speaking, the provider is responsible for contacting the UM department to request preservice review for both professional and institutional services. However, the hospital or ancillary provider should contact UniCare to verify preservice review status for all nonurgent care before rendering services. The hospital can confirm that an authorization is on file by calling 1-800-782-0095 or using the Interactive Care Reviewer (ICR) via Availity. If coverage of an admission has not been approved, the facility should call UniCare’s UM department at 1-866-655-7423 to start the UM process.

UniCare is available by fax or ICR 24 hours a day, 7 days a week to accept prior authorization requests. When a request for medical services is received from the physician via telephone or fax, the intake representative will verify eligibility and benefits. This information will be forwarded to the prior authorization nurse.

The prior authorization nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures.
When the clinical information received is in accordance with the definition of medical necessity and in conjunction with appropriate, evidence-based criteria, an authorization will be issued. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member’s needs and medical history.

If the prior authorization documentation is incomplete or inadequate, the prior authorization nurse will not approve coverage of the request and will refer the request to the UniCare medical director. When appropriate, the prior authorization nurse will assist the provider in identifying alternatives for health care delivery as supported by the medical director. If the medical director denies the request, the appropriate denial letter (including the member’s appeal rights) will be sent to the requesting provider, the member’s PCP and the member.

If you disagree with a UM decision and want to discuss the decision with the physician reviewer, call the UM department at 1-866-655-7423 and ask to be connected to the peer-to-peer line. All peer-to-peer discussions must be requested within one business day of the denial notification.

**Utilization Management**

**Services Requiring Prior Authorization**

Some common services requiring prior authorization include, but are not limited to:

- Advanced radiology services
- All out-of-network services
- Behavioral health: See the Behavioral Health Provider Manual for specifics
- Dental services: Contact Scion Dental for specifics
- Durable medical equipment
- Genetic testing
- Home health care services, including hospice care
- Inpatient hospital services including:
  - Newborn stays beyond federally mandated timeframes
  - Rehabilitation facility admissions
- Sleep studies and treatment for sleep disorders
- Select outpatient surgeries/procedures including but not limited to:
  - Tonsillectomy
  - Hysterectomy
  - Bariatric surgery
- Vision services: contact VSP for specifics

The Precertification Lookup Tool Online (PLUTO) can assist with determining a code’s precertification requirements, located in the Authorization and Preservice Review section of the Provider Resources page. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

**Utilization Management**

**Services Not Requiring Prior Authorization**

The following services do not require prior authorization for in-network providers:

- Behavioral health screening and assessment
- Emergency services (notify UniCare within 24 hours or the next business day of inpatient admission)
- Family planning/well-woman checkups:
- Birth control
- Breast and pelvic exams
- U.S. Food and Drug Administration (FDA)-approved devices and supplies for family planning
- Genetic counseling
- Screening for HIV or sexually transmitted infections (STIs)
- Lab work

- Nebulizers
- Obstetrical care:
  - In-network physician visits and routine testing: no authorization required.
  - Pregnancy notification: Notification of pregnancy is required using the West Virginia Department of Health & Human Resources Prenatal Risk Screening Instrument (PRSI) located on their website at http://www.wvdhhr.org/mcfh/WV_PrenatalRiskScreeningInstrument2016.pdf and at www.unicare.com (see below for steps). Complete the entire form and fax it to 1-877-833-5729 or email it to prsi.unicare@anthem.com.
- Physical and occupational therapy (subject to limits)
- Physician referrals (for in-network specialists, consultation or a nonsurgical course of treatment)
- Services where UniCare is the secondary payor
- Standard X-rays and ultrasounds (limited to one prenatal ultrasound per normal pregnancy)

Please note: For benefits to be paid, the member must be eligible on the date of service and the service must be a covered benefit. Except in an emergency, failure to obtain prior authorization may result in a denial for reimbursement.

The PRSI and Newborn Enrollment Notification Report form are in the Forms and Tools section of the Provider Resources page on our website at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Utilization Management

UM or Prior Authorization Toolkit

Our UM Toolkit, also referred to as the Prior Authorization Toolkit, may be found in the UM Toolkit on the Provider Resources page of our website at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website. The toolkit contains the most recent versions of our Request for Pre-Service Review for State Sponsored Business form and the link to PLUTO, which assists with determining a code’s preauthorization requirements.
Utilization Management

Starting the Process
When authorization of a health care service is required, contact us with questions and requests, including requests for:

• Routine, nonurgent care reviews
• Urgent or expedited preservice reviews
• Urgent concurrent or continued stay reviews

An urgent request is any request for authorization of medical care or treatment that cannot be delayed because delay would result in one of the following:

• Could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, based on a prudent layperson’s judgment
• Would subject the member to severe pain that could not be adequately managed without the care or treatment that is the subject of the request. This assessment must be made by a practitioner with knowledge of the member’s medical condition
• A delay in discharge from an inpatient facility

The UM department returns calls:

• Same day when the call is received during normal business hours
• Next business day when the call is received after normal business hours
• Within 24 hours for all routine requests

Providers may fax the UM department and include requests for:

• Urgent or expedited preservice reviews
• Nonurgent concurrent or continued stay reviews

Faxes are accepted during and after normal business hours. Faxes for nonurgent requests received after hours will be processed the next business day.

In addition, ICR is a real-time prior authorization system through the Availity Portal where authorization requests can be completed, edited and submitted electronically. Alerts are sent to a providers email address when the status of the authorization changes, or additional information is needed. All phoned, or faxed authorization requests are also available in the dashboard of the ICR system.

Our Interactive Care Reviewer (ICR) is the preferred method for submitting prior authorization requests, offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for our members. Additionally, providers can use this tool to make inquiries on previously submitted requests, regardless of how they were sent (phone, fax, ICR or other online tool). Capabilities and benefits of the ICR include:

• Initiating preauthorization requests online eliminating the need to fax. The ICR allows detailed text, photo images and attachments to be submitted along with your request.
• Making inquiries on previously submitted requests via phone, fax, ICR or other online tool.
• Having instant accessibility from almost anywhere, including after business hours.
• Utilizing a dashboard that provides a complete view of all utilization management requests with real-time status updates, including email notifications if requested using a valid email address.
• Viewing real-time results for common procedures with immediate decisions.
To register for an ICR webinar, go to https://bit.ly/2z394yL.

You can access the ICR under Authorizations and Referrals on the Availity Portal (https://www.availity.com). For an optimal experience with the ICR, use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox and Safari. The ICR is not currently available for:

- Transplant services.
- Services administered by vendors, such as AIM Specialty Health® and OrthoNet LLC. For these requests, follow the same prior authorization process you use today.

**Utilization Management**

**Requesting Authorization**

To request a preservice review or report a medical admission, call, fax or submit a request electronically through the ICR from the Availity Portal for UniCare. Have the following information ready:

- Member name and identification (ID) number
- Diagnosis with the ICD code
- Procedure with the CPT code
- Date of injury or hospital admission
- Third-party liability information (if applicable)
- Facility name, TIN and NPI (if applicable)
- PCP
- Specialist or attending physician name, TIN and NPI
- Clinical justification for the request
- Level of care
- Lab tests, radiology and pathology results
- Medications
- Treatment plan, including time frames
- Prognosis
- Psychosocial status and history
- Exceptional or special needs issues
- Ability to perform activities of daily living
- Discharge plans

All providers, including physicians, hospitals and ancillary providers are required to provide information to the UM department. Physicians are encouraged to review their utilization and referral patterns. Additional information to have ready for the clinical reviewer includes:

- Office and hospital records
- History of the presenting problem
- Clinical exam
- Treatment plans and progress notes
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and Providers
- Photographs
- Operative and pathological reports
- Rehabilitative evaluations
- Printed copy of criteria related to the request
Utilization Management

Authorization Forms

UniCare offers a variety of forms to help providers with preauthorization of services, available in the UM Toolkit on the Provider Resources page of our website at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website. The toolkit contains the most recent versions of our Request for Preservice Review for State Sponsored Business form and the link to PLUTO, which assists with determining a code’s preauthorization requirements.

Generally speaking, the provider is responsible for contacting the UM Department to request preservice review for both professional and institutional services. However, the hospital or ancillary provider should contact UniCare to verify preservice review status for all nonurgent care before rendering services.

Here are some tips for filling out the forms and getting the fastest response to your authorization request:

• Fill out the form online and fax to ensure legibility. If you print and then complete the blank form, print legibly.
• Fill out the form completely; unanswered questions typically result in delays.
• Access the forms online as needed rather than preprinting and storing forms. Because we revise the forms periodically, outdated forms can delay your request.
• Ensure that you have the billing details for all providers to ensure that claims pay correctly
• Access the ICR from the Availity Portal for electronic submission of prior authorization requests.

Utilization Management

Requests with Insufficient Clinical Information

When the UM department receives requests with insufficient clinical information, we will contact the provider with a request for the information reasonably needed to determine medical necessity. We will make at least one attempt to contact the requesting provider to obtain this additional information. If we do not obtain a response within the specified time frame after receiving the request, we will issue a the appropriate denial letter, including the member’s appeal rights, to the hospital, the member’s PCP and the member.

Utilization Management

Preservice Review Time Frame

For routine, nonurgent requests, the UM department will complete preservice reviews within 7 calendar days of receiving the request. This 7-day review period may be extended up to 14 additional calendar days upon request of the member or provider, or if UniCare receives written approval from the West Virginia Bureau for Medical Services (BMS) in advance that the member will benefit from such extension.
Utilization Management

Urgent Preservice Requests
For urgent preservice requests, the UM department completes the preservice review within two business days of the receipt of the request. This includes requests for DME when a member is hospitalized and the DME is required for timely discharge.

Utilization Management

Emergency Medical Conditions and Services
UniCare does not require prior authorization for treatment of emergency medical conditions. In the event of an emergency, members may access emergency services 24/7. In the event that the emergency room visit results in the member’s admission to the hospital, providers must contact UniCare the next business day following admission or post-stabilization. Failure to comply with notification rules will result in an administrative denial. UniCare intake staff will verify eligibility and determine benefit coverage. UniCare is available via fax at 1-855-402-6985 or ICR 24 hours a day, 7 days a week to accept emergent admission notification.

Coverage of emergent admissions is authorized based on review by a concurrent stay review (CSR) nurse. When the clinical information received meets MCG criteria, an authorization will be issued to the hospital. If the notification documentation provided is incomplete or inadequate, the CSR nurse will not approve the request and will refer the request to the UniCare medical director. If the medical director denies coverage of the request, the appropriate denial letter, including the member’s appeal rights, will be sent to the hospital, the member’s PCP and the member.

Members who call their PCP’s office reporting a medical emergency (whether during or after office hours) are directed to dial 911 or go directly to the nearest hospital emergency department. All nonemergent conditions should be triaged by the PCP or treating physician, with appropriate care instructions given to the member.

Utilization Management

Emergency Stabilization and Post-Stabilization
The emergency department’s treating physician determines the services needed to stabilize the member’s emergency medical condition. After the member is stabilized, the emergency department’s physician must contact the member’s PCP for authorization of further services. The member’s PCP is noted on the ID card. If the PCP does not respond within one hour, all necessary emergency services will be considered authorized by the PCP.

The emergency department should send a copy of the emergency room record to the PCP’s office within 24 hours. The PCP should:

- Review and file the chart in the member’s permanent medical record
- Contact the member
- Schedule a follow-up office visit or a specialist referral, if appropriate

As with all nonelective admissions, notification must be made the next business day. The medical necessity of the admission will be reviewed upon receipt of the notification. A determination of the medical necessity will be rendered within 24 hours of the notification. Failure to comply with notification rules will result in an administrative denial. UniCare intake staff will verify eligibility and
determine benefit coverage. UniCare is available via fax at 1-855-402-6985 or ICR 24 hours a day, 7 days a week to accept emergent admission notification.

Utilization Management
Referrals to Specialists
The Customer Service or Case Management departments are available to assist providers in identifying a network specialist and/or arranging for specialty care. Keep in mind the following when referring members. Authorization is:

- Not required if referring a member to an in-network specialist for consultation or a nonsurgical course of treatment.
- Required when referring a member to an out-of-network specialist.
- Required for an out-of-network referral when an in-network specialist is not available in the geographical area.

Provider responsibilities include documenting referrals in the member’s chart and requesting that the specialist provide updates about diagnosis and treatment. Treatment provided by the specialist must be appropriate for the member’s condition.

Please note: Obtain a prior authorization approval number before referring members to an out-of-network provider. For out-of-network providers, we require prior authorization for the initial consultation and each subsequent service provided. Failure to obtain authorization prior to services being rendered can result in denial of claims payment.

Utilization Management
Out-of-Network Exceptions
There are geographical exceptions to using only in-network providers:

- UniCare members are allowed to use the services of out-of-network nurse practitioners if no nurse practitioner is available in the member’s service area.
- UniCare makes covered services provided by federally qualified health centers (FQHCs) and rural health clinics (RHCs) available to members out-of-network if those clinics are not available in the member’s service area and within UniCare’s network.
- If UniCare is unable to provide necessary covered medical services by UniCare’s provider network, UniCare authorizes out-of-network services and covers the services for as long as those services are not available in-network.

Utilization Management
Continued Stay Review: Hospital Inpatient Admissions
Hospitals must notify the UM department of inpatient medical admissions within 24 hours of admission or by the next business day. If there is insufficient clinical information to determine medical necessity, the provider is contacted with a request for the clinical information reasonably necessary to make this determination. Evidence-based criteria are used to determine medical necessity and the appropriate level of care.

Note: Failure to notify UM within the designated time frame can result in an administrative denial of services.
Utilization Management

Continued Stay Review: Clinical Information for Continued Stay Review

When a member’s hospital stay is expected to exceed the number of days authorized during preservice review, or when the inpatient stay did not require preservice review (that is, emergency admission), the hospital must contact us for continued stay review. We require clinical reviews on all members admitted as inpatients to:

- Acute care hospitals
- Intermediate facilities.
- Inpatient rehabilitation facilities (when covered)

Note: Failure to notify UM within the designated time frame can result in an administrative denial of services.

We perform these reviews to assess medical necessity and determine whether the facility and level of care are appropriate. UniCare identifies members admitted as inpatients by:

- Facilities reporting admissions.
- Providers reporting admissions.
- Preservice authorization requests for inpatient care.

The UM department will complete continued-stay inpatient reviews within 24 hours of receipt of the request, consistent with the member’s medical condition. UM staff will request clinical information from the hospital on the same day they are notified of the member’s admission and/or continued stay. If the information meets medical necessity review criteria, we will approve the request within 24 hours of receipt of the information. We will send requests that do not meet medical policy guidelines to the physician advisor or medical director for further review.

We will send written notification to the member and requesting provider of any denial or modification of the request.

Utilization Management

Denial of Service

Only the medical director or doctorate level practitioners with an active professional license or certification can deny services for lack of medical necessity, including the denial of:

- Procedures.
- Hospitalization.
- Equipment.

Note: Denials related to non-notification or failure to obtain prior authorization can be made administratively, without medical director review.

When a request is determined to be not medically necessary, the requesting provider will be notified of:

- The decision.
- The process for appeal.
- How to reach the reviewing physician for peer-to-peer discussion of the case.
- The reason and the criteria used to make the decision.
Providers may contact the physician clinical reviewer to discuss any UM decision by calling the peer to peer line at 866-902-4628, option 3 within one business day of the denial notification.

Utilization Management

Self-Referral
Members do not need prior authorization and may self-refer for the following services when rendered by qualified, in-network providers:

- Emergency services
- Family planning, including an annual examination provided by an OB/GYN
- Immunizations
- Behavioral health screening and assessment

Utilization Management

Second Opinions
Second opinions are covered services. The following are important guidelines regarding second opinions:

- A second opinion must be given by an appropriately-qualified health care professional.
- The second opinion must come from a provider of the same specialty.
- The secondary specialist must be within UniCare’s network and may be selected by the member.

When there is no network provider who meets the specified qualification, we may authorize a second opinion by a qualified provider outside of the network, upon request by the member or provider. A second opinion regarding medical necessity is a covered service, offered at no cost to our members.

Utilization Management

Additional Services: Behavioral Health
Behavioral health services are covered by UniCare. To request authorization for services prior to being rendered and hospital/facility admission notification, contact UniCare’s Utilization Management (UM) department:

- Phone: 1-866-655-7423
- Behavioral Health Inpatient Fax: 1-855-325-5556
- Behavioral Health Outpatient Fax: 1-855-325-5557
- Hours: Monday to Friday, 8 a.m.-5 p.m.
- Website: www.unicare.com
- ICR through the Availity Portal at http://www.availity.com

Utilization Management

Additional Services: Vision Care
UniCare contracts with Vision Service Plan providers for basic vision care. For prior authorization of all vision services, contact 1-866-615-1883 (TTY: 1-800-428-4833).

Utilization Management

Additional Services: Dental Care
UniCare covers emergency dental services only for adults 21 years of age and older. These services may be given by a dentist or oral surgeon.
We cover:
• Treatment of fractures of the upper or lower jaw
• Biopsy
• Removal of tumors
• Removal of a tooth when it is an emergency

For details about dental service coverage for children up to 21 years of age, refer to the *Dental Services: Dental Screening and Referral for Children Ages 0 to 21* section.
CHAPTER 7: HEALTH SERVICES PROGRAMS

Customer Care Center phone: 1-800-782-0095
Customer Care Center fax: 1-888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Health Services Programs
Overview
UniCare’s health services programs are designed to improve our members’ overall health and well-being by informing, educating and encouraging self-care in the early detection and treatment of existing conditions and chronic disease. These targeted programs supplement providers’ treatment plans and are divided into the following categories:

- Preventive care programs, including the initial health assessment and well woman programs
- Health management programs (e.g., Condition Management promotes knowledge and encourages self-care for specific medical conditions and chronic disease, while New Mother and Baby Post Delivery Outreach is a program designed to identify mothers and babies with post-delivery needs)
- Health education, including the 24/7 NurseLine for all health-related questions (in addition, an Emergency room action campaign instructs members on the proper use of emergency room services)

Health Services Programs
Healthy Rewards
Our Healthy Rewards program helps our members earn $20, $25 or $50 for their very own Healthy Rewards account by getting certain health services. At the same time, you increase your practice’s quality scores by providing them with the vaccinations, screenings, visits and medications they need. Every time our members complete one of the healthy activities, they get dollars added to their Healthy Rewards card. They can then spend these Healthy Rewards dollars at specific retailers on a variety of approved over-the-counter items they can use to stay healthy.

To help you in your practice, all our Healthy Rewards activities are tied to HEDIS® scores and health initiatives. They include:

<table>
<thead>
<tr>
<th>Who’s eligible</th>
<th>Healthy Activities</th>
<th>Reward</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children (less than 2 weeks old)</td>
<td>Well Baby 2 Week Visit</td>
<td>$25</td>
<td>Once per child</td>
</tr>
<tr>
<td>Children (0-15 months)</td>
<td>Six Ongoing Well-Baby Visits</td>
<td>$25</td>
<td>Once per child</td>
</tr>
<tr>
<td>Children (ages 3-6)</td>
<td>Well Child Visit</td>
<td>$25</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Adolescents (ages 12-21)</td>
<td>Adolescent Well Care Visit</td>
<td>$25</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Females (ages 50-75)</td>
<td>Complete Breast Cancer Screening</td>
<td>$25</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Females (21-64)</td>
<td>Complete Cervical Cancer Screening</td>
<td>$25</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Adults with diabetes (ages 18-75)</td>
<td>Diabetic Eye Exam</td>
<td>$25</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td></td>
<td>Diabetic Blood Sugar (HbA1c) and Kidney Test</td>
<td>$50</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Members (ages 6 and up) who have been discharged from a hospital for a mental health condition</td>
<td>Outpatient visit with mental health practitioner within 7 days of discharge from mental health hospital.</td>
<td>$20</td>
<td>Once per discharge; Maximum of 4x every 12 months</td>
</tr>
</tbody>
</table>
Pregnant Women

<table>
<thead>
<tr>
<th>1st prenatal visit (within 42 days of enrollment)</th>
<th>$25</th>
<th>Once per pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six prenatal care visits</td>
<td>$25</td>
<td>Once per pregnancy</td>
</tr>
<tr>
<td>Postpartum Visit between 21-56 days after delivery</td>
<td>$25</td>
<td>Once per pregnancy</td>
</tr>
</tbody>
</table>

Please remind your patients about our Healthy Rewards program at their next office visit. By working together, we can help our members get the right care while they earn rewards. And we help you improve your scores and encourage good health habits with your patients, our members.

If your patients have questions regarding the program, please have the member call 1-877-868-2004 for more information.

**Health Services Programs**

**Preventive Care: Health Screenings and Immunizations**

One of the best ways to promote and protect good health is to prevent illness. UniCare members are covered for routine health screenings and immunizations. Additionally, our health services programs provide members with guidelines, reminders and encouragement to stay well. Our members may receive:

- Information about health issues
- Flu shot reminders
- Health screening reminders, such as breast and cervical cancer screenings

**Provider Responsibilities**

The following are provider responsibilities that help members maintain healthy lifestyles:

- Document all health care screenings, immunizations, procedures, health education and counseling in the member’s medical record.
- Provide immunizations as needed at all well-child visits and according to the schedule established by the Advisory Committee on Immunization Practices (ACIP), American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP).
- Refer members to dentists, optometrists/ophthalmologists or other specialists as needed; document referrals in the member’s medical record.
- Schedule preventive care appointments for all children following the AAP periodicity schedule.

**Health Services Programs**

**Preventive Care: Initial Health Assessments**

The initial health assessment (IHA) gives providers the baseline necessary to assess and manage a member’s physical condition. Once the IHA has been completed, providers can give our members the kind of educational support that allows members to become more actively engaged in their own treatment and preventive health care.

The IHA of new members should be performed by the PCP within 90 days of enrollment. The IHA consists of the following categories of patient information:

- Patient history
- Physical examination
- Developmental assessment
Please note: An IHA is not necessary under the following conditions:

- If the new member is an existing patient of the PCP but is new to UniCare, and has an established medical record showing baseline health status. This record must include sufficient information for the PCP to understand the member’s health history and provide treatment recommendations as needed.
- If the new member is not an existing patient, transferred medical records meet the requirements for an IHA if a complete health history is included.

Health Services Programs

Preventive Care: HealthCheck

In West Virginia, HealthCheck is the name given to the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program for children. HealthCheck is a preventive health care program for children from birth to age 21. The program covers initial and periodic examinations and medically necessary follow-up care. As an integral part of this program, PCPs may provide age-appropriate preventive care screening and testing during each well-child visit and during an acute illness episode, if appropriate.

HealthCheck Screening Requirements

PCPs should offer health education, counseling and guidance to the member, parent or guardian. An evaluation of age-appropriate risk factors should be performed at each visit. In addition, PCPs should perform the following:

- A comprehensive health and developmental history, including both physical and mental health development
- A comprehensive, unclothed physical exam, including pelvic exams and Pap tests for sexually active females
- Appropriate immunizations according to age and health history
- Dental screenings; refer to a dentist for children age 3 and older
- Vision testing
- Documented and current immunizations
- Health education, as necessary
- Laboratory tests, including screenings for blood lead levels and hearing
- Nutritional assessment
- Tuberculosis screening
- Behavioral health screening

UniCare HealthCheck Responsibilities

Information on our preventive care programs is provided in UniCare’s Member Handbook, which is sent to members at the time of enrollment. Member newsletters and the member website include special features about the HealthCheck program, and ongoing reminders on the importance of an IHA, well-child visits, immunizations and regular checkups.

In addition, UniCare provides services, which may include live calls, Interactive Voice Response (IVR) outreach, or mailed materials to reach out to members as outlined below:

- IHA reminders to all newly-enrolled members within 30 days of enrollment
- Immunization reminders to the parents/guardians of members under 2 years old
- Annual preventive care/well visit reminders to members 2 through 20 years of age on their birth months
Health Services Programs

Preventive Care: Childhood Lead Exposure Testing and Free Blood Test Kits

CMS requires that all children enrolled in Medicaid be tested for lead exposure at 1 and 2 years of age. Children from 3 to 6 years of age who have not been tested need screening regardless of their risk factors.

Please note: Completion of a lead risk assessment questionnaire does not fulfill this screening requirement; a blood draw is required.

To order your free MEDTOX lead exposure blood testing kits, call MEDTOX toll free: 1-800-334-1116. You may establish an account and arrange for an initial order. Establishing an account with MEDTOX allows you to re-order kits when necessary.

Health Services Programs

Preventive Care: Well Woman

The Well Woman program was designed to remind and encourage women to have regular cervical and breast cancer screenings. The Well Woman Reminder Program sends a screening test reminder mailer to women who are not up-to-date with their recommended screenings. Providers are encouraged to refer members for screenings and/or schedule the exams.

PCP responsibilities for the care of female members include:

- Educating members on Preventive Health Care Guidelines for women
- Referring members for cervical cancer and breast cancer screenings
- Scheduling screening exams for members

Providers may access the Preventive Health Care Guidelines in the Quality Improvement Program section of the Provider Resources page on our website at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Health Services Programs

Health Management: Taking Care of Baby and Me®

Taking Care of Baby and Me is a proactive case management program for all expectant mothers and their newborns. It identifies pregnant women as early in their pregnancies as possible through review of state enrollment files, claims data, lab reports, hospital census reports, the Prenatal Risk Screening Instrument and provider delivery notification forms, and self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. Case managers collaborate with community agencies to ensure mothers have access to necessary services, including transportation, WIC, home-visitor programs, breastfeeding support and counseling.

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That’s why we encourage all of our moms-to-be to take part in our program, which offers:

- Individualized, one-on-one case management support for women at the highest risk
- Care coordination for moms who may need a little extra support
- Educational materials and information on community resources
- Rewards to keep up with prenatal and postpartum checkups and well-child visits after the baby is born

As part of the Taking Care of Baby and Me program, members are offered the My Advocate™ program. This program provides pregnant women proactive, culturally appropriate outreach and education through interactive voice response (IVR), text or smart phone application. This program does not replace the high-touch case management approach for high-risk pregnant women; however, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers and improve member and baby outcomes. Eligible members receive regular calls with tailored content from a voice personality (Mary Beth). For more information on My Advocate, visit https://www.myadvocatehelps.com.

For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the You and Your Baby in the NICU program and a NICU Post-Traumatic Stress Disorder (NICU PTSD) program. Parents receive education and support to be involved in the care of their babies, visit the NICU, interact with hospital care providers and prepare for discharge. Parents are also provided with an educational resource outlining successful strategies they may deploy to collaborate with the care team. The NICU PTSD program seeks to improve outcomes for families of babies who are in the NICU by screening and facilitating referral to treatment for PTSD in parents. This program will support mothers and families at risk for PTSD due to the stressful experience of having a baby in the NICU.

**Provider Assessment of Pregnancy Risk**
The PCP or prenatal care physician should assess all pregnant members for high-risk indicators during the initial prenatal care visit. For all pregnant members, the provider needs to:
- Email a completed *Prenatal Risk Screening Instrument (PRSI)* to prsi.unicare@anthem.com with “SECURE PRSI” in the subject line or fax it to 1-877-833-5729 within seven days of the first prenatal visit or as soon as possible. The PRSI form is available in Forms and Tools > Form Library section of the Provider Resources page of our website at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.
- Members identified as high risk (teens, those with a history of substance abuse, those with a history of preterm birth, or those with serious health conditions) are referred to the high-risk obstetrical (HROB) team. High-risk members receive close monitoring and interaction from HROB nurse case managers. These members also have access to additional resources before and after giving birth.
- Refer members to prenatal education, childbirth education and breastfeeding classes; members register by calling the Case Management Department at 1-304-347-2475.
- Document all referrals in the member’s medical record.
- Schedule the member for a postpartum visit.

**Breastfeeding Support Tools and Services**
The American Academy of Pediatrics, the American College of Obstetrics and Gynecology, and the American Public Health Association recognize breastfeeding as the preferred method of infant feeding.
Providers should encourage breastfeeding for all pregnant women unless breastfeeding is not medically appropriate. To support this goal, we ask you to:

- Assess all pregnant women for health risks that are contraindications to breastfeeding, such as AIDS and active tuberculosis.
- Provide breastfeeding counseling and support to postpartum women immediately after delivery.
- Assess postpartum women to determine the need for lactation durable medical equipment, such as breast pumps and breast pump kits.
- Document all referrals and treatments related to breastfeeding in the member’s medical record. Pediatricians should document frequency and duration of breastfeeding in the baby’s medical record.
- Refer members to prenatal classes prior to delivery by calling the Case Management Department at 1-304-347-2475.
- Refer pregnant women to community resources that support breastfeeding such as Women, Infants and Children (WIC) at the WIC website: https://ons.wvdhhr.org. From the menu bar at the top of the page, select Breastfeeding. Select from topics on Breastfeeding, Lactation Services, Food Package, Update or Breastfeeding Training. Or members may call 1-304-558-0030.
- Support continued breastfeeding during the postpartum visit.

Health Services Programs

Health Management: New Mother and Baby Post-Delivery Outreach Program

The New Mother and Baby Post-Delivery Outreach Program is designed to identify mothers and babies with post-delivery support needs. UniCare will contact new mothers by telephone within four days of receipt of the Newborn Enrollment Notification Report. The purpose of this call is to find out if new mothers have any post-delivery needs, questions or require any resources. UniCare will confirm that the mothers have postpartum and well-baby appointments scheduled with their providers within 21-56 days of the delivery. A second call will be made 14 days after the first call.

The program allows UniCare and providers to:

- Establish eligibility for care management programs
- Ensure mothers and babies receive appropriate medical care
- Increase postpartum and well-baby follow-up visits
- Enhance member engagement
- Increase quality health care outcomes for mothers and their babies
- Raise HEDIS® scores

For this initiative to be effective, providers should submit the Newborn Enrollment Notification Report to UniCare within three days of delivery. The form is available in the Forms and Tools > Form Library section of the Provider Resources page of our website at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

If you have any questions about the New Mother and Baby Post-Delivery Outreach Program, contact UniCare at 1-800-782-0095.
Health Services Programs

**Health Education: 24/7 NurseLine**

We recognize that questions about health care prevention and management do not always come up during office hours. The 24/7 NurseLine, a phone line staffed by registered nurses, offers a provider support system and is a component of after-hours care. The 24/7 NurseLine allows members to closely monitor and manage their own health by providing the ability to ask questions whenever they come up. This phone line is available 24 hours a day, 7 days a week at **1-888-850-1108**.

Members may call the 24/7 NurseLine for:
- Self-care information, including assistance with symptoms, medications and side-effects, and reliable self-care home treatments
- Access to specialized nurses trained to discuss health issues specific to our teenage members
- Information on more than 300 health care topics through the audio tape library

Providers may use the 24/7 NurseLine as a resource for members to call for nonemergent questions and information.

Please note: Nurses have access to telephone interpreter services for members who do not speak English. All calls are confidential.

Health Services Programs

**Health Education: Emergency Room Action Campaign**

Too often, our members use hospital emergency rooms as their first stop for nonemergent conditions. The Emergency Room Action Campaign (ER Action Campaign) was designed to cut down on the number of inappropriate emergency room visits by identifying members who use the emergency room for the wrong reasons. With this initiative, we can help members understand that nonemergency, preventive and follow-up care should always take place in their PCP’s office.

The ER Action Campaign increases member visits to their PCP by educating members about:
- Seeking care for nonemergency events
- Contacting their PCP first before going to the ER
- Alternatives to ER use
- Importance of follow-up care by their PCPs

The ER Action Campaign is a multi-pronged communication program that includes the following:
- IVR calls made to members identified through a clinical analysis of members’ medical claims. The IVR provides a predefined, finite list of barriers for the member to select to identify the reason for going to the ER rather than to a PCP.
- After completing the call, members either are warm transferred to the outbound call center (OBC) or are given information about how to contact the 24/7 NurseLine. The OBC also helps members who need information about their PCP or transportation assistance. The 24/7 NurseLine helps members determine if they have a medical emergency requiring a visit to the ER and provides assistance with other concerns, such as filling medications.
- A member’s responses from the IVR call are used to generate a customized mailing to the member. The mailing addresses the barriers identified during the IVR call and provides resources the member can use instead of going to the ER, such as visiting their PCP.
We rely on the support of the providers, who remind members that the PCP’s office and the 24/7 NurseLine should be their first stops for nonemergency conditions. Working together, we can replace the automatic urge to go to the emergency room with the more appropriate action of picking up the phone or returning to the PCP’s office.

Health Services Programs
Health Education: Weight Watchers Membership
Weight Watchers® membership is available with a PCP referral. UniCare provides eligible members with the Weight Watchers program at no cost. Because Weight Watchers offers multiple weight loss plans, members can choose the option that fits their needs best. The program is open to adults 18 years of age and older. In addition, Weight Watchers is open to children from 10 to 17 years of age who are referred by their PCP and have their parents’ consent. For more information about the program, members may call the UniCare Health Plan of West Virginia:
Toll-free phone: 1-888-611-9958
Local phone: 1-304-347-1961

Health Services Programs
Health Education: Tobacco Cessation Programs
UniCare’s tobacco cessation program is a health education program in the form of a booklet developed by the National Cancer Institute called Clearing the Air. This booklet enables each member to create a personalized “smoking cessation plan” by providing guidelines on how to prepare to quit. With this resource, the member is educated on the benefits of quitting, what to expect when they quit, health risks associated with tobacco use and strategies to become smoke free. The Smoking Cessation program provides each individual with the support, resources and motivation to successfully achieve their goal.

Smoking Cessation offers numerous tools and resources to help members who want to quit smoking. The booklet Clearing the Air will be mailed to members upon request. Members or providers may view or download the Clearing the Air booklet by visiting either of the websites listed below. Additionally, the following websites provide a wealth of information about tobacco use that can be used to promote smoking cessation:
- Smokefree.gov
- Pubs.cancer.gov: The National Cancer Institute

The Smoking Cessation program helps members in any stage of cessation readiness and includes the following:
- UniCare offers smoking cessation classes to members at no cost; call the Customer Care Center for more information
- Nicotine replacement therapy (NRT) — when prescribed by a provider

Smoking cessation clinical practice guidelines are posted on our website at www.unicare.com.
1. Select OTHER UNICARE WEBSITES: Providers at the top of the screen.
2. In the Resources for section, select State Sponsored Plan providers.
3. Select West Virginia – Medicaid Managed Care.
4. Select Clinical Practice Guidelines

Provider Assessment of Tobacco Use
The following are provider guidelines to help members quit smoking:
• Assess the member’s smoking status and offer advice about quitting.
• Use the online *Prenatal Risk Screening Instrument* as a way to notify us, through the West Virginia Bureau for Medical Services (BMS), of pregnant women who smoke. The form is available on our website at [www.unicare.com](http://www.unicare.com).
• Encourage pregnant women to stop smoking and not resume after pregnancy.
• Offer members resources to stop smoking, including information on our Smoking Cessation program.
• Refer members to West Virginia’s Tobacco Quit Line, a free, phone-based counseling service:
  o Phone: **1-877-966-8784**
  o Hours: Monday to Friday, 8 a.m.-8 p.m.; Saturday and Sunday, 8 a.m.-5 p.m.
• West Virginia’s Tobacco Quit Line services include:
  o Individual coaching
  o Resources for providers who want to improve patient outcomes
  o Support for family and friends who want to help loved ones stop smoking
• Refer members to National Institutes of Health smoking cessation phone at **1-800-QUIT-NOW** (1-800-784-8669)

**Additional Resources to Help Members Stop Smoking**

UniCare offers the following educational resources to help women who are pregnant or of childbearing age to quit smoking, avoid starting again, or avoid exposure to secondhand smoke. To download a copy, access the *Health Education Programs: Programs to Keep You Well* section on the *Provider Resources* page of our website at [www.unicare.com](http://www.unicare.com). Select from the following documents:
• Quit Smoking for Your Baby’s Sake
• Yes, You CAN Quit Smoking
• Avoiding Second Hand Smoke

For directions on how to access the *Provider Resources* of our website, please see *Chapter 1: How to Access Information, Forms and Tools on Our Website*.

Provider types who may perform tobacco cessation counseling include the following:
• Physicians
• Physician assistants
• Nurse practitioners
• Registered nurses
• Psychologists
• Pharmacists
• Dentists

Counseling is required as a part of any covered tobacco cessation course of treatment.
CHAPTER 8: CLAIMS AND BILLING

Customer Care Center phone:  1-800-782-0095
Customer Care Center fax:   1-888-438-5209
Hours of operation:  Monday to Friday, 8 a.m. to 6 p.m.

Claims and Billing
Overview
Having a fast and accurate system for processing claims allows providers to manage their practices and our members’ care more efficiently. With that in mind, UniCare has made claims processing as streamlined as possible. Share the following guidelines with your staff, billing service and electronic data processing agents:
• Submit clean claims, making sure that the right information is on the right form.
• Submit claims as soon as possible after providing service.
• Submit claims within the contract filing time limit.

Additional information covered in this chapter includes the following:
• Covered services
• Clinical submission categories
• Benefit codes
• Submitting present on admission indicators
• Submitting pregnancy notification reports
• National drug codes
• Common reasons for rejected and returned claims

Claims Editing
UniCare uses claims editing software which incorporates editing rules to determine whether a claim should be paid, rejected or undergo manual processing. These editing rules assess CPT and HCPCS codes on the CMS-1500 claim form. A claim auditing action determines how the procedure codes and code combinations will be used to settle the claim. The auditing action recognizes historical claims related to current submissions and may result in adjustments to previously processed claims. Descriptions of specific reimbursement policies are available in this manual.

Edits may be updated periodically. UniCare will notify providers in advance when required. For the latest information and current editing rules, log on to our website at www.unicare.com.

Clear Claim Connection
Clear Claim Connection is a web-based tool enabling providers to review the claim auditing rules and clinical rationale of the claim processing software. Providers may access Clear Claim Connection through the Availity web portal at https://www.availity.com to prescreen claims and inquire on claim disposition.

Claims and Billing
Submitting Clean Claims
Claims submitted correctly the first time are called clean, meaning that all required fields have been filled in and that the correct form was used for the specific type of service provided. The provider is responsible for all claims submitted using the provider number, regardless of who completed the claim
If you use a billing service, you must ensure that your claims are submitted properly by the service.

A claim submitted with incomplete or invalid information may be returned. If you use the Electronic Data Interchange (EDI), claims will be returned for incomplete or invalid information. Claims may also be returned if they are not submitted with the proper HIPAA-compliant code set. In each case, an error report will be sent to you and the claim will not be sent through for payment. You and your staff are responsible for working with your EDI vendor to ensure that “errored out” claims are corrected and resubmitted.

Generally, the types of forms you will need for reimbursement are:
- CMS-1500 for professional services: [www.cms.gov/Medicare/CMS-Forms](http://www.cms.gov/Medicare/CMS-Forms)

These forms are available in both electronic and hard copy/paper formats. **Please note:** Using the wrong form, or not filling out the form correctly or completely, causes the claim to be returned, resulting in processing and payment delays.

**Claims and Billing**

**ICD-10**

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

**What is ICD-10?**

International Classification of Diseases, 10th Revision (ICD-10) is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes; and in the United States, the codes are the foundation for documenting the diagnosis and associated services provided across health care settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:
- ICD-10-CM (Clinical Modification) used for diagnosis coding, and
- ICD-10-PCS (Procedure Coding System) used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaced the code sets, ICD-9-CM, Volumes 1 and 2 for diagnosis coding, and ICD-10-PCS replaced ICD-9-CM, Volume 3, for inpatient hospital procedure coding.

**Claims and Billing**

**Claims Filing Limits**

Claims must be submitted within the contracted filing limit to be considered for payment. Claims submitted after that time period will be denied.

**Please note:** UniCare is not responsible for a claim never received. If a claim is submitted inaccurately, prolonged periods before resubmission may cause you to miss the filing deadline. Claims must pass
basic edits to be considered received. To avoid missing deadlines, submit clean claims as quickly as possible after delivery of service.

Filing limits are determined as follows:
• If UniCare is the primary payer, use the length of time between the last date of service on the claim and UniCare’s receipt date.
• If UniCare is the secondary payer, use the length of time between the other payer’s remittance advice (RA) date and UniCare’s receipt date.

Claims and Billing
Claim Forms and Filing Limits
Refer to the provider contract to confirm the time limits to file.

<table>
<thead>
<tr>
<th>Form</th>
<th>Type of service to be billed</th>
<th>Time limit to file</th>
</tr>
</thead>
</table>
| CMS-1500 Claim Form   | • Physician and other professional services  
                         • Specific ancillary services including:  
                           o Audiologists  
                           o Ambulance  
                           o Ambulatory surgical center  
                           o Dialysis  
                           o Durable medical equipment  
                           o Diagnostic imaging centers  
                           o Hearing aid dispensers  
                           o Home infusion  
                           o Home health  
                           o Hospice  
                           o Laboratories  
                           o Occupational therapy  
                           o Orthotics  
                           o Physical therapy  
                           o Prosthetics  
                           o Skilled nursing facility (SNF)  
                           o Speech therapy  
                           Note: Some ancillary providers may use a CMS-1450 claim form if they are ancillary institutional providers. Ancillary charges by a hospital are considered facility charges. |
|                       |                                                                                             | Within 180 days of service date              |
| CMS-1450 Claim Form   | Hospitals, institutions and home health services                                           | Within 180 days of service date              |
## Claims and Billing
### Other Filing Limits

<table>
<thead>
<tr>
<th>Action</th>
<th>Type of Service to be Billed</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Third-Party Liability (TPL) or Coordination of Benefits (COB)</strong></td>
<td>If the claim has TPL, COB or requires submission to a third party before submitting to UniCare, the filing limit starts from the date on the notice from the third party.</td>
<td>File within 180 days of notice from the third-party vendor.</td>
</tr>
<tr>
<td><strong>Checking Claim Status</strong></td>
<td>Claim status may be checked any time by calling the Customer Care Center Interactive Voice Response (IVR) system.</td>
<td>30 business days after UniCare’s receipt of a claim, submit a Follow-Up Request Form. Or, call the Customer Care Center IVR.</td>
</tr>
<tr>
<td><strong>Claim Follow-Up Request</strong></td>
<td>Submit a corrected claim after UniCare’s denial or correction to a claim, or to follow up on a claim using the Claim Follow-Up Form. To access this form, go to the Forms and Tools section of the Provider Resources page of our website at <a href="http://www.unicare.com">www.unicare.com</a>. For directions on how to access the Provider Resources page, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.</td>
<td>180 calendar days from the date of our remittance advice.</td>
</tr>
<tr>
<td><strong>Mailback Form</strong></td>
<td>UniCare sends a request for additional information to you when we cannot process your claim due to incomplete, missing or incorrect information in the original claim submission.</td>
<td>Return the requested information within 180 calendar days. In your response, include a copy of the Mailback Form you received, all supporting documentation deemed pertinent or requested by us (such as records or reports), and a copy of the original/corrected claim.</td>
</tr>
<tr>
<td><strong>Claim Filing with Wrong Health Plan/Insurance Carrier</strong></td>
<td>If the claim was mistakenly filed with the wrong health plan or insurance carrier, you may submit to us with the proper documentation for payment.</td>
<td>Provide documentation verifying the initial timely filing. Submit to us within 180 days of the date of the other carrier’s denial letter or RA form. We will process your claim without denial for failure to file within time limits.</td>
</tr>
<tr>
<td><strong>Provider Dispute</strong></td>
<td>Submit a claim reconsideration request in writing to UniCare Health Plan of West Virginia, Inc. Attn: Grievances and Appeals P.O. Box 91 Charleston, WV 25321-0091</td>
<td>365 days from the receipt of our RA</td>
</tr>
<tr>
<td><strong>UniCare’s Response to Provider Dispute Resolution Request</strong></td>
<td>This process provides UniCare with response time to investigate and make a determination.</td>
<td>UniCare sends an acknowledgement within 15 calendar days of receipt of the dispute. We make a determination within 45 business days of receipt of the dispute.</td>
</tr>
</tbody>
</table>
Claims and Billing

Methods for Submission

The methods for submitting a claim are as follows:

- Electronically through EDI (preferred)
- Paper or hard copy

Electronic submission through UniCare’s EDI is preferred for accuracy, convenience and speed. Providers will receive notification within 24 hours that an electronic claim has been submitted.

After filing a paper claim, you should receive a response from UniCare within 30 business days after we receive the claim. If the claim contains all required information, UniCare enters the claim into the claims system for processing and sends you a RA when the claim is finalized.

Claims and Billing

Electronic Claims

Electronic filing methods are preferred for accuracy, convenience and speed. EDI allows providers and facilities to submit and receive electronic transactions from their computer systems. EDI is available for most common health care business transactions.

To offer you the most detailed information about EDI, we have dedicated a website to sharing billing information with providers and EDI vendors, including clearinghouses, software vendors and billing agencies. This information includes details on how to submit, receive and troubleshoot electronic transactions. To access all EDI manuals, forms and communications, go to www.unicare.com/edi. The following is available online:

- EDI registration information and forms
- EDI contacts and support information
- EDI communications and electronic submission tips
- Information on electronic filing benefits and cost-savings
- Filing instructions for EDI submission of eligibility, benefit and claim status inquiries
- The UniCare HIPAA Companion Guide and EDI User Guide with complete information on submitting and receiving electronic transactions
- UniCare report descriptions
- Lists of clearinghouses, software vendors and billing agencies
- Frequently Asked Questions (FAQ) about electronic transactions
- Information and links to the HIPAA website
- Contractual agreements with our trading partners

Providers and vendors may contact the UniCare EDI Solutions Helpdesk:

Phone: 1-800-470-9630
Hours of operation: Monday to Friday, 11 a.m. to 7:30 p.m.
EDI Solutions email: E-Solutions.support@unicare.com
Web address/live chat: www.unicare.com/edi
UniCare’s payer ID number: 80314
Claims and Billing

National Provider Identifier
The NPI is a 10-digit, all numeric identifier. NPIs are issued only to providers of health services and supplies. As a provision of HIPAA, the NPI is intended to improve efficiency and reduce fraud and abuse. NPIs are divided into the following types:

- Type 1: Individual providers, including, but not limited to, physicians, dentists and chiropractors
- Type 2: Hospitals and medical groups, including, but not limited to, hospitals, group practices, federally qualified health centers (FQHCs) and rural health clinics (RHCs)

For billing purposes, NPIs should be used with the following guidelines:

- Claims must be filed with the appropriate NPI for billing, rendering and referring providers.
- The NPI must be attested with the West Virginia BMS in the same manner as with UniCare, including the effective dates for individual providers within groups.
- Claims will be denied when the NPI listed is not the same number attested with BMS.

Attestation: The process of registering and reporting your NPI with your state Medicaid agency.

Providers may apply for a NPI online at the National Plan and Provider Enumeration System (NPPES) website at [https://nppes.cms.hhs.gov/NPPES](https://nppes.cms.hhs.gov/NPPES). Select Apply Online for an NPI, Login or Create Login to View or Update your NPI Data. Or obtain a paper application by calling NPPES at 1-800-465-3203.

The following websites offer additional NPI information:

- NPPES: [https://npiregistry.cms.hhs.gov](https://npiregistry.cms.hhs.gov)
- Workgroup for EDI: [http://www.wedi.org](http://www.wedi.org)
- National Uniform Claims Committee: [www.nucc.org](http://www.nucc.org)

Claims and Billing

Use of Referring Provider’s NPI on Claims Submissions
If the PCP refers a member to a specialist or another provider, the PCP must give his/her NPI number to the specialist or provider. The specialist or provider is required to add the referring PCP’s NPI when submitting claims for the member. If the PCP does not provide his/her NPI at the time of referral, the billing provider is responsible for obtaining that information. The billing provider may do so by calling the PCP’s office or by going online to the NPI Registry website at [https://npiregistry.cms.hhs.gov](https://npiregistry.cms.hhs.gov).

There are exceptions to the requirement of providing the referring PCP’s NPI:

- If a provider is on call or covering for another provider. In this case, the billing provider must complete Box 17b of the CMS-1500 claim form to receive reimbursement.
- If the provider is in the same provider group, or has the same tax ID or NPI as the referring provider and is an approved provider type
- Services were provided after-hours
- Emergency services were performed in place of service 23
- Family planning services
- Diagnostic specialties such as lab and X-ray services
- Anesthesia claims
- Professional inpatient claims
- Obstetrics/gynecology claims
If the billing or referring provider is from an FQHC or urgent care center

Also note that members may self-refer for certain services, including family planning services and emergency services.

Claims and Billing

Unattested NPIs
UniCare will deny claims with an unattested NPI, even if you provide legacy information. Providers serving West Virginia Medicaid patients are required to register and attest their NPIs with West Virginia’s BMS. You can attest your NPI on the BMS website at www.dhhr.wv.gov/bms.

Claims and Billing

Paper Claims
Paper claims are scanned for clean and clear data recording. To get the best results, paper claims must be legible and submitted in the proper format. Follow these requirements to speed processing and prevent delays:

- Use the correct form and be sure the form meets CMS standards.
- Use black or blue ink. Do not use red ink because the scanner may not be able to read red ink.
- Use the “remarks” field for messages.
- Do not stamp or write over boxes on the claim form.
- Send the original claim form to UniCare and retain a copy for your records.
- Do not staple original claims together; UniCare will consider the second claim to be an attachment and not an original claim to be processed separately.
- Remove all perforated sides from the form. To help our equipment scan accurately, leave a ¼-inch border on the left and right sides of the form after removing perforated sides.
- Type information within the designated field. Be sure the type falls completely within the text space and is properly aligned.
- Do not highlight any fields on the claim forms or attachments. Highlighting increases the difficulty in creating a clear electronic copy during scanning.
- If using a dot matrix printer, do not use “draft mode” because the characters generally do not have enough distinction and clarity for the optical scanner to read accurately.

If you submit paper claims, include the following provider information:

- Provider name
- Rendering provider group or billing provider
- Federal provider tax identification number (TIN)
- NPI
- Medicare number, if applicable
- UniCare’s Payer ID Number: 80314

Please note: Some claims may require additional attachments. Be sure to include all supporting documentation when submitting your claim. Claims with attachments should be submitted on paper.

Mail paper claims to:
UniCare Health Plan of West Virginia, Inc.
Attn: Initial Claims Processing
P.O. Box 91
Charleston, WV 25321-0091
Claims and Billing

Paper Claims Processing

All paper claims submitted are assigned a unique document control number (DCN). The DCN identifies and tracks claims as they move through the claims processing system. This number contains the Julian date, which indicates the date the claim was received. DCNs are composed of 11 digits:

- 2-digit plan year
- 3-digit Julian date
- 2-digit UniCare reel identification
- 4-digit sequential number

Claims entering the system are processed on a line-by-line basis except for inpatient claims, which are processed on a whole claim basis. Each claim is subjected to a comprehensive series of checkpoints called edits. These edits verify and validate all claim information to determine if the claim should be paid, denied or pended for manual review.

Claims and Billing

Member Balance Billing

Providers contracted with UniCare may not balance bill our members, meaning that members cannot be charged for covered services above the amount UniCare pays to the provider. A West Virginia BMS program provider may bill a member only when all of the following conditions have been met:

- The service is not covered or the member has exceeded the program limitations.
- The member understands, before services are rendered, that the service is not covered and that the member is responsible for the charges associated with the service.
- The provider documents that the member voluntarily chose to receive the service and that the member was informed in advance that he or she was receiving a noncovered service.

Please note: A generic consent form is not acceptable unless the form identifies the specific procedure to be performed and the member signs the consent before receiving the service. Refer to the West Virginia BMS Provider Manual for more information at www.dhhr.wv.gov/bms. Providers are prohibited from collecting copays for missed appointments.

Providers may balance bill a member when prior authorization of a covered service is denied. However, the provider must establish and demonstrate compliance with all of the following:

- Establish that prior authorization was requested and denied before rendering service.
- Submit a request to review UniCare’s authorization decision.
- Notify the member that the service requires prior authorization and that UniCare has denied authorization. If out-of-network, the provider must explain to the member that covered services may be available without cost when provided by an in-network provider. In such cases, authorization of service is required.
- Inform the member of his or her right to file an appeal if the member disagrees with the decision to deny authorization.
- Inform the member of his or her responsibility for payment of nonauthorized services.

If the provider chooses to use a waiver to establish member responsibility for payment, the waiver must meet the following requirements. The waiver:

- Was signed after the member received appropriate notification.
• Does not contain any language or condition specifying that the member is responsible for payment in the case of denial of authorization.
• Is specific to each member visit that falls under the scenario of the noncovered service; providers may not use nonspecific waivers. The form must be obtained for each member visit.
• Specifies the:
  o Services that fall under the waiver’s application.
  o Date the services will be provided.

The provider has the right to appeal lack of payment resulting from a denial of authorization.

Claims and Billing
Coordination of Benefits
UniCare may coordinate benefits with any other health care program that covers our members. Indicate other coverage information on the appropriate claim form. If you need to coordinate benefits, include at least one of the following items from the other health care program when submitting a coordination of benefits (COB) claim:
• Third-party remittance advice (RA)
• Third-party provider explanation of benefits (EOB)
• Third-party letter explaining either the denial of coverage or reimbursement

COB claims received without at least one of these items will be mailed back to you with a request to submit to the other health care program first. Make sure the information you submit explains all coding listed on the other carrier’s RA or letter. We cannot process the claim without this specific information.

Members who have primary insurance other than Medicaid are exempt from Medicaid cost-sharing obligations. When a third party has made a payment for a covered service and UniCare is the secondary payer, the Medicaid-allowed amount shall be calculated as the difference between the paid amount and the Medicaid-allowed amount compared to the sum of the coinsurance, copayment and deductible amounts. UniCare is responsible for paying the lesser of either.

Claims and Billing
Claims Filed With the Wrong Plan
If you initially filed a claim with the wrong insurance carrier, UniCare will process your claim without denying the claim for not filing within the time limit if you:
• Document that the claim was initially filed in a timely manner
• File the claim within 180 days of the date of the other carrier’s denial letter or RA form

Claims and Billing
Payment of Claims
After receiving a claim, we take the following steps:
1. UniCare analyzes the claim for covered services.
2. UniCare generates a RA statement, summarizing the services rendered and the action taken.
3. If payment is warranted, UniCare sends the appropriate payment to the provider.
   -or-
If payment is not warranted, UniCare sends an RA to the provider with the specific claims processing information.

UniCare will adjudicate a clean electronic claim within 30 calendar days of the date the claim is received. Clean paper claims are processed within 30 calendar days. UniCare will pay interest on clean claims not adjudicated within these time frames. This policy is in alignment with BMS reimbursement policies. Interest will be paid to the in-network provider at 7% per annum, calculated daily for the full period in which the clean claim remains unpaid beyond the 30-day clean claim payment deadline.

**Claims and Billing**

*Monitoring Submitted Claims*

Monitor claims status through the Customer Care Center’s IVR system at 1-800-782-0095. Correct any errors and resubmit immediately to prevent denials due to late filing.

*Please note:* The IVR accepts either your NPI or your federal TIN for the provider ID. Should the system not accept those numbers, your call will be redirected to the Customer Care Center. For purposes of assisting you, we may ask again for your TIN.

You may also monitor submitted claims by logging on to the secure provider portal at https://www.availity.com. Log in using your user ID and password or select Register. To register, you will need your federal TIN, organizational name and NPI. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

**Claims and Billing**

*Electronic Remittance Advice*

UniCare offers secure electronic delivery of RAs, which explain claims in their final status, using EDI. You may find more information about EDI in the Electronic Claims section of this chapter.

**Claims and Billing**

*Electronic Funds Transfer*

UniCare allows electronic funds transfer (EFT) for claims payment transactions, meaning that claims payments may be deposited directly into a previously selected bank account. Providers seeking to register or manage account changes for EFT only or EFT and ERA combined will need to use the Council for Affordable Quality Health Care (CAQH) Enrollment tool, a secured electronic EFT/ERA registration platform. This tool will help eliminate the need for paper registration and reduce administrative time and costs and allow you to register with multiple payers at one time.

Providers previously registered with UniCare to receive combined EFT/ERA or EFT only will register with CAQH to manage account changes, but otherwise do not need to take action. Paper registration forms for combined EFT/ERA or EFT only are being discontinued and are no longer available.

To register for EnrollHub®, go to www.caqh.org and under CAQH Solutions Login, select EnrollHub®.
Claims and Billing

Claims Overpayment Recovery Procedure

UniCare seeks recovery of all excess claims payments from the person or entity to whom the benefit check is made payable. When an overpayment is discovered, UniCare initiates the overpayment recovery process by sending written notification.

Refund notifications may be identified by two entities, UniCare and its contracted vendors or the providers. UniCare researches and notifies the provider of an overpayment requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by UniCare, UniCare will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment.

If a provider identifies an overpayment and submits a refund, a completed Refund Notification Form specifying the reason for the return must be included. This form can be found on the provider website at www.unicare.com. The submission of the Refund Notification Form will allow Cost Containment to process and reconcile the overpayment in a timely manner. For questions regarding the refund notification procedure, please call the Customer Care Center at 1-800-782-0095.

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. In the event the outcome of this reconciliation results in a net amount owed to us, we will commence recovery of such amounts through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

Changes addressing the topic of overpayments have taken place with the passage of the Patient Protection and Affordable Care Act (PPACA), commonly known as the Healthcare Reform Act. The provision directly links the retention of overpayments to false claim liability. The language of 42 U.S.C.A. § 1320a-7k makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act, including treble damages. In order to avoid such liability, health care providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

The provision entitled Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments, codified at 42 U.S.C.A. § 1320a-7k, clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act. This provision of the HealthCare Reform Act applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

UniCare seeks recovery of all excess claims payments from the person or entity to whom the benefit check is made payable. When an overpayment is discovered, UniCare initiates the overpayment recovery process by sending written notification.
If you are notified by UniCare of an overpayment, or discover that you have been overpaid, mail the
check, along with a copy of the notification or other supporting documentation within 30 days to the
appropriate address:

UniCare Health Plan of West Virginia, Inc.
Attn: Overpayment Recovery
P.O. Box 73651
Cleveland, OH 44193

For overnight delivery:

UniCare Health Plan of West Virginia, Inc.
Attn: Overpayment Recovery
Lockbox 92420
4100 West 150th St.
Cleveland, OH 44135

If you believe the overpayment notification was created in error, contact UniCare’s Provider Services
department by phone at 1-800-782-0095.

For claims re-evaluation, send your correspondence to the address indicated on the overpayment
notice. If UniCare does not hear from you or receive payment within 30 days, the overpayment amount
will be deducted from your future claims payments. In cases where UniCare determines that recovery is
not feasible, the overpayment will be referred to a collection service.

**Claims and Billing**

**Third-Party Recovery**
Providers may not interfere with or place any liens upon West Virginia’s right or UniCare’s right, acting
as West Virginia’s agent, to obtain recovery from third-party billing.

**Claims and Billing**

**Hospital Readmissions Policy**
UniCare does not reimburse for readmission for a related condition within seven days of discharge from
a previous hospital confinement, in accordance with the BMS policy for readmissions. Claims for new
admission fees for hospital readmission will be denied.

**Claims and Billing**

**Claims Returned for Additional Information**
UniCare will send you a request for additional or corrected information when the claim cannot be
processed due to incomplete, missing or incorrect information. The request includes a form allowing you
to return the requested information in an easy-to-follow format. This Claim Follow-up Form must be
returned with the requested information. UniCare will use this same form to request additional
information retroactively for a claim already paid. Provide any additional information within 180
calendar days from the date of the request or your claim may be denied.

To submit additional or corrected information, you should send:

- A copy of the letter requesting more information
All supporting documentation you believe to be important or that was specifically requested by UniCare

Please note: Many of the claims returned for further information are returned for common billing errors. For additional information and tips, refer to the Reference: Common Reasons for Rejected and Returned Claims section of this chapter.

Claims and Billing
Claim Resubmissions
When resubmitting a claim, use a Claim Follow-Up Form. The resubmission must be received by UniCare within 180 days from the date on the EOB or letter. Include the following information:

- Complete all required fields as originally submitted and mark the change(s) clearly.
- Write or stamp Corrected Claim across the top of the form.
- Attach a copy of the EOB and state the reason for resubmission.
- Send to:
  UniCare Health Plan of West Virginia, Inc.
  Attn: Claims Resubmissions
  P.O. Box 91
  Charleston, WV 25321-0091

Please note: You may send corrected CMS-1450 claim forms electronically. The third digit of the type of bill should indicate a correction or cancellation to the original submission.

If there has been no response from UniCare 30 business days after claim submission, follow up to determine the status. To follow up on a claim:

- Verify that the claim was not rejected by EDI or returned by mail.
- Call the Customer Care Center IVR at 1-800-782-0095.
- Check the secure provider portal at https://www.availity.com. Log in using your user ID and password or select Register. To register, you will need your federal TIN, organizational name and NPI. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Please note: The IVR system accepts either your billing NPI or your federal TIN for provider ID. Should the system not accept those numbers, your call will be redirected to a Customer Care Center representative for assistance.

Claims and Billing
Claim Disputes
If there is a full or partial claim rejection or the payment is not the amount expected, submit a claims dispute request. The request must be made in writing to UniCare. For more information, refer to Chapter 12: Grievances and Appeals

Claims and Billing
Claim Correspondence
Claim correspondence is different from a payment dispute. Correspondence is when UniCare requires more information to finalize a claim. Typically, UniCare makes the request for this information through
the Remittance Advice. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, UniCare will use it to finalize the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

<table>
<thead>
<tr>
<th>Type of Issue</th>
<th>What Do I Need to Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rejected Claim(s)</td>
<td>Use the EDI Hotline at 1-800-590-5745 when your claim was submitted electronically but was never paid or was rejected. We’re available to assist you with setup questions and help resolve submission issues or electronic claims rejections.</td>
</tr>
<tr>
<td>RA Requests for Supporting Documentation (Itemized Bills and Invoices)</td>
<td>Submit a Claim Follow-up Form, a copy of your RA and the supporting documentation to: UniCare Health Plan of West Virginia, Inc. Attn: Claims P.O. Box 91 Charleston, WV 25321-0091</td>
</tr>
<tr>
<td>RA Requests for Medical Records</td>
<td>Submit a Claim Follow-up Form, a copy of your RA and the medical records to: UniCare Health Plan of West Virginia, Inc. Attn: Claims P.O. Box 91 Charleston, WV 25321-0091</td>
</tr>
<tr>
<td>Need to Submit a Corrected Claim due to Errors or Changes on Original Submission</td>
<td>Submit a Claim Follow-up Form and your corrected claim to: UniCare Health Plan of West Virginia, Inc. Attn: Claims P.O. Box 91 Charleston, WV 25321-0091</td>
</tr>
<tr>
<td></td>
<td>Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 180 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to UniCare to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI EOB.</td>
</tr>
<tr>
<td>Submission of Coordination of Benefits (COB)/Third-Party Liability (TPL) Information</td>
<td>Submit a Claim Follow-up Form, a copy of your RA and the COB/TPL information to: UniCare Health Plan of West Virginia, Inc. Attn: Claims P.O. Box 91 Charleston, WV 25321-0091</td>
</tr>
<tr>
<td>Type of Issue</td>
<td>What Do I Need to Do?</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Claims and Billing**

**Medical Necessity Appeals**
Medical necessity appeals refer to a situation in which an authorization for a service was denied prior to the service. Medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process.

**Claims and Billing**

**Reference: Covered Services**
For billing purposes, the following are considered covered services:
- Ambulance
- Chiropractic
- Clinic services: general clinics, birthing centers, lab and radiology centers, health department clinics, RHCs, FQHCs
- Dental services for adults (emergency only)
- Dental services for children
- Durable medical equipment (DME), supplies, and prosthetic devices
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT; covers hearing, vision, dental, nutritional needs, health care treatment, routine shots and immunizations, and lab tests for children under 21 years of age. Also referred to as West Virginia HealthCheck.)
- Family planning services and supplies
- Handicapped children’s services/children with special health care needs services
- Home health care services
- Hospice services
- Hospital services: inpatient and outpatient
- Lab and radiology (not received in a hospital)
- Nurse practitioner services
- Physical or occupational therapy, speech pathology and audiology
- Physician (doctor) services
- Podiatry services (foot care)
- Pregnancy and maternity care
- Private duty (covered for members under the age of 21)
- Transportation (emergency only)
- Vision services for children
- Vision services for adults (medical treatments only)

For a comprehensive list of covered services, access the benefit matrix documents located on our Provider Resources page on www.unicare.com. Scroll to the Forms and Tools section and select Benefit Matrix for Children or Benefit Matrix for Adults. These benefit matrix documents provide the differences in benefits between the Mountain Health Trust and West Virginia Health Bridge programs.

These documents change when the state updates contracts; keep this page bookmarked for easy access to the most current information. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.
For coverage specifics, please refer to the BMS fee schedules located at www.dhhr.wv.gov/bms/FEES/Pages/default.aspx.

Claims and Billing

Reference: Clinical Submission Categories

The following is a list of claim categories for which we may routinely require submission of clinical information before or after payment of a claim. If the claim:

- Involves precertification, prior authorization, predetermination or some other form of utilization review, including, but not limited to, claims that are:
  - Pending for lack of precertification or prior authorization
  - Involving medical necessity or experimental/investigative determinations
  - Involving physician-administered drugs that require prior authorization
- Requires certain modifiers, including, but not limited to, modifier 22
- Includes unlisted codes
- Is under review to determine if the service is covered. Benefit determination cannot be made without reviewing medical records. This category includes, but is not limited to, pre-existing condition issues, emergency service/prudent layperson reviews and specific benefit exclusions
- Involves possible inappropriate or fraudulent billing and is under review
- Is the subject of an internal or external audit, including high-dollar claims
- Involves individuals under case or disease management
- Is under appeal or is otherwise the subject of a dispute, including claims being mediated, arbitrated or litigated

Other situations in which clinical information might be routinely requested:

- Accreditation activities
- Coordination of benefits
- Credentialing
- Quality improvement/assurance efforts
- Recovery/subrogation
- Requests relating to underwriting, including, but not limited to, member or provider misrepresentation/fraud reviews and stop-loss coverage issues

Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

Claims and Billing

Reference: Benefit Codes

Submit claims with the appropriate benefit code for services, as required:

- For electronic claims, add the benefit code in SBR Loop 2000B, SBRO3.
- For paper claims, add the benefit code in Box 11c on the CMS-1500 claim form.

If a benefit code is not applicable, leave the field blank.
Claims and Billing

Reference: Submitting Present on Admission Indicators

To comply with federal regulations, providers must include the present on admission (POA) indicators for paper and electronic inpatient claims. POA indicators demonstrate whether or not a condition was present when the member was admitted, or if the condition occurred while the member was in the facility. Include a POA indicator for each “primary” and “other” diagnosis code. Do not submit a POA indicator for the “admitting” diagnosis code.

Acceptable POA indicators are:
- **Y** - Yes, present at the time of admission.
- **N** - No, not present at the time of admission.
- **U** - Unknown. The documentation is insufficient to determine if the condition was present or not at the time of admission.
- **W** - Clinically undetermined. The provider is unable to determine clinically whether or not the condition was present at the time of inpatient admission.
- **1, ‘space’, or ‘left blank’** - Valid if either the facility or the diagnosis code is exempt from reporting of POA.

Claims and Billing

Reference: Submitting Pregnancy Notification Reports

When submitting claims regarding a member’s pregnancy, providers must:
- Submit the *Prenatal Risk Screening Instrument (PRSI)* to UniCare within seven days of the first prenatal visit or as soon as possible. A completed *PRSI* must be emailed to prsi.unicare@anthem.com with “SECURE PRSI” in the subject line or faxed to 1-877-833-5729.
- Use CPT Code 99213, along with the TH modifier when billing UniCare for each prenatal visit. When billing UniCare for an ultrasound or fetal non-stress test, also use modifier 25. Use modifier 25 only if you document a distinct, separately identifiable reason for the visit in the member’s record.

Claims and Billing

Reference: National Drug Codes

Providers must include national drug codes (NDCs), unit of measurement and quantity of drug on all UniCare claims, including physician-administered drugs. This applies to drugs dispensed in both professional and institutional outpatient settings.

West Virginia’s BMS requires that UniCare report NDC information every month. BMS submits this data to pharmaceutical manufacturers to obtain rebates under the Medicaid Drug Rebate Program. Following these instructions is important for West Virginia to receive timely Medicaid Drug Rebates from drug manufacturers.

UniCare will deny professional and outpatient institutional claims containing physician-administered drugs if any of the following elements are missing or invalid:
- NDCs
- Unit of measurement
- Quantity of drug
Please note: The NDC is an 11-digit code on the package or container from which medication is administered.

**Claims and Billing**

**Reference: Common Reasons for Rejected and Returned Claims**

Many claims are returned for common billing errors, as defined in the table below.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Explanation</th>
<th>Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member’s ID Number is Incomplete</td>
<td>Missing the correct Member ID number listed on the state’s ID card.</td>
<td>Use the Member’s Medicaid ID number on the state’s ID card.</td>
</tr>
<tr>
<td>Duplicate Claim Submission</td>
<td>Overlapping service dates for the same service create a question about duplication. Claim was submitted to UniCare twice without additional information for consideration.</td>
<td>List each date of service, line by line, on the claim form. Avoid spanning dates, except for inpatient billing. Read RAs for important claim determination information before resubmitting a claim. Additional information may be needed. A corrected claim needs to be clearly marked as “Corrected” so that we do not process the claim as a duplicate.</td>
</tr>
<tr>
<td>Authorization Number Missing/Does Not Match Services</td>
<td>The Authorization Number is missing, or the approved services do not match the services described in the claim.</td>
<td>Confirm the Authorization Number is provided on the claim form and that approved services match the provided services. On the CMS-1500 claim form, use Box 24. On the CMS-1450 claim form, use Box 63. Contact the Utilization Management department to revise the service for authorization if changes occur.</td>
</tr>
<tr>
<td>Missing Codes for Required Service Categories</td>
<td>Use current HCPCS and CPT manuals because changes are made to the codes quarterly or annually. Purchase manuals at any technical bookstore, through the American Medical Association (AMA) or the Practice Management Information Corporation.</td>
<td>Check the codebooks or ask someone in your office who is familiar with coding. Use only those codes recognized by BMS. Therefore, Providers must check BMS billing instructions.</td>
</tr>
<tr>
<td>Unlisted Code for Service</td>
<td>Because some procedures or services do not have an associated code, use an unlisted procedure code.</td>
<td>UniCare needs a description of the procedure and medical records in order to calculate reimbursement. DME, prosthetic devices, hearing aids or blood products require a manufacturer’s invoice. For drugs/injections, the J code is required.</td>
</tr>
<tr>
<td>By Report Code for Service</td>
<td>Some procedures or services require additional information.</td>
<td>UniCare needs a description of the procedure, as well as medical records in order to calculate reimbursement. DME, prosthetic devices, hearing aids</td>
</tr>
<tr>
<td>Problem</td>
<td>Explanation</td>
<td>Resolution</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>or blood products require a manufacturer’s invoice. For drugs/injections, the J code is required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unreasonable Numbers Submitted</td>
<td>Unreasonable numbers, such as “9999”, may appear in the Service Units fields.</td>
<td>Check your claim for accuracy before submitting the claim.</td>
</tr>
<tr>
<td>Submitting Batches of Claims</td>
<td>Stapling multiple claims together may make the subsequent claims appear to be attachments rather than individual claims.</td>
<td>Clearly identify each individual claim and do not staple to another claim.</td>
</tr>
<tr>
<td>Nursing Care</td>
<td>Nursing charges are included in the hospital and outpatient care charges. Nursing charges billed separately are considered unbundled charges and are not payable. In addition, UniCare will not pay claims using different room rates for the same type of room to adjust for nursing care.</td>
<td>Do not submit bills for nursing charges.</td>
</tr>
<tr>
<td>Hospital Medicare ID Missing</td>
<td>The Medicare ID number is required to process hospital claims at their appropriate contracted rates.</td>
<td>On the CMS-1450 claim form, hospitals must enter their Medicare ID number in Box 51.</td>
</tr>
</tbody>
</table>
CHAPTER 9: BILLING PROFESSIONAL AND ANCILLARY CLAIMS

Customer Care Center phone: 1-800-782-0095
Customer Care Center fax: 1-888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Professional Billing and Ancillary Claims

Overview

Providers can depend on efficient claims handling and faster reimbursement when they follow UniCare’s professional and ancillary billing requirements. These requirements include using standardized codes for most health services. This chapter is broken into health service categories to help you find the specific billing codes you need for each service.

You will also find information on billing members for services that are not medically necessary or not covered, billing for services for which the member is willing to pay, and complete information about completing the CMS-1500 claim form.

To help you navigate the various billing requirements and codes, we have organized the service categories as follows:

- Adult preventive care
- Emergency services
- Family planning services
- Hospital readmission policy
- Immunizations covered by the Vaccines For Children (VFC) Program
- Immunization administration procedures covered under VFC
- Immunizations not covered by VFC
- Initial health assessments (IHAs)
- Maternity services
- Newborns
- On-call services
- Preventive medicine services: new patient
- Preventive medicine services: established patient
- Self-referable services
- Sensitive services
- Sterilization claims

General Guidelines

For the most efficient claims processing, accurately completed claims are essential. Follow these general guidelines for claims filing:

- Indicate the provider’s NPI number in Box 24J of the CMS-1500 claim form. Missing or invalid numbers may result in nonpayment.
- Mid-level practitioners (such as physician assistants) should put the supervising provider’s NPI number in Box 24J of the CMS-1500 claim form.
- Nurse practitioners and certified nurse midwives are credentialed providers and therefore enter their own NPI number in Box 24J.
- Use the member’s ID number from the UniCare ID card.
Please note: UniCare does not accept global billing codes. If we receive a claim with global coding, we will return the claim to you with a Mailback Form asking you to rebill using itemized codes.

Professional Billing and Ancillary Claims

Coding
UniCare uses standardized codes in our effort to process claims in an orderly and consistent manner. HCPCS, sometimes referred to as national codes, provides coding for a wide variety of services. The principal coding levels are referred to as level I and level II:
- Level I: CPT codes maintained by the American Medical Association (AMA) and represented by five digits.
- Level II: Codes that identify products, supplies and services not included in the CPT codes, such as ambulance supplies and durable medical equipment (DME). Level II codes sometimes are called the alphanumeric codes because they consist of a single alphabetical letter followed by four digits.

In some cases, two-digit/character modifier codes should accompany the level I or level II coding. Reference guides useful for coding claims are:

Professional Billing and Ancillary Claims

National Drug Codes
Providers must include National Drug Codes (NDCs) on all claims involving products or services with an NDC. UniCare submits this NDC information to West Virginia with encounter claims submissions.

Professional Billing and Ancillary Claims

Initial Health Assessments
UniCare PCPs function as a member’s medical home. For that reason, we strongly recommend that an IHA be conducted within 90 days of the member’s date of enrollment. The IHA should consist of a complete history, a physical exam and preventive services.

When billing for IHAs, use the following ICD diagnosis codes:
- Z00.121 for children (newborn to 18 years old)
- Z00.00 for adults (19 years and older)

Professional Billing and Ancillary Claims

Adult Preventive Care
The following is a list of codes specific to adult preventive care:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>82270</td>
<td>Fecal Occult Blood Test (lab procedure code only)</td>
</tr>
<tr>
<td>82465</td>
<td>Total Serum Cholesterol (lab procedure code only)</td>
</tr>
<tr>
<td>84153</td>
<td>PSA (lab procedure code only)</td>
</tr>
<tr>
<td>86580</td>
<td>Tuberculosis (TB) Screening (PPD)</td>
</tr>
<tr>
<td>88150</td>
<td>Pap Smear (lab procedure code only)</td>
</tr>
<tr>
<td>90658</td>
<td>Flu Shot</td>
</tr>
<tr>
<td>90718</td>
<td>Td-Diphtheria-Tetanus Toxoid-0.5 ml</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------</td>
</tr>
<tr>
<td>90732</td>
<td>Pneumovax</td>
</tr>
</tbody>
</table>

Professional Billing and Ancillary Claims

Preventive Medicine Services: New Patient
Preventive medicine services for a new patient start with an IHA. This evaluation includes an age- and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory and diagnostic procedures. Bill for these services using the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381</td>
<td>Infant (under 1 Year)</td>
</tr>
<tr>
<td>99382</td>
<td>Early Childhood (ages 1-4)</td>
</tr>
<tr>
<td>99383</td>
<td>Late Childhood (ages 5-11)</td>
</tr>
<tr>
<td>99384</td>
<td>Adolescent (ages 12-17)</td>
</tr>
<tr>
<td>99385</td>
<td>Ages 18-39</td>
</tr>
<tr>
<td>99386</td>
<td>Ages 40-64</td>
</tr>
<tr>
<td>99387</td>
<td>Ages 65 and older</td>
</tr>
</tbody>
</table>

Professional Billing and Ancillary Claims

Preventive Medicine Services: Established Patient
Preventive medicine services for an established patient involve re-evaluation and management of existing conditions, if any. This evaluation includes an age- and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory and diagnostic procedures.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99391</td>
<td>Infant (under 1 year)</td>
</tr>
<tr>
<td>99392</td>
<td>Early Childhood (ages 1-4)</td>
</tr>
<tr>
<td>99393</td>
<td>Late Childhood (ages 5-11)</td>
</tr>
<tr>
<td>99394</td>
<td>Adolescent (ages 12-17)</td>
</tr>
<tr>
<td>99395</td>
<td>Ages 18-39</td>
</tr>
<tr>
<td>99396</td>
<td>Ages 40-64</td>
</tr>
<tr>
<td>99397</td>
<td>Ages 65 and older</td>
</tr>
</tbody>
</table>

Professional Billing and Ancillary Claims

Self-Referable Services
Members may access the following services at any time without preauthorization or referral by their PCP:
- Family planning, associated services and other sensitive services, supplies, or medications to members of childbearing age to temporarily or permanently prevent or delay pregnancy
- Obstetrics/gynecology (OB/GYN; in-network only from UniCare providers)
- Emergency care
- Vision care
Professional Billing and Ancillary Claims

Emergency and Related Professional Services

Emergency services, as defined by state and local law, the provider contract, and our Member Handbook, are reimbursed in accordance with the UniCare Provider contract and West Virginia’s Bureau for Medical Services (BMS) policy.

Please note: Prior authorization is not required for medically necessary emergency services.

Emergency: Any condition manifesting itself by acute symptoms of sufficient severity such that a layperson possessing an average knowledge of health and medicine could reasonably expect that the absence of immediate medical care could:

- Place the member’s health in serious jeopardy. Or, with respect to a pregnant woman, the health of the woman and her unborn child
- Cause serious impairment to bodily functions
- Cause serious dysfunction to any bodily organ or part

Covered emergency services include:

- Hospital-based emergency services (room and ancillary) needed to evaluate or stabilize the emergency medical or behavioral health condition
- Services by emergency providers

Professional Billing and Ancillary Claims

Family Planning Services

The following is a list of diagnostic codes specific to family planning services:

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T8331XA</td>
<td>Breakdown (mechanical) of intrauterine contraceptive device, initial encounter</td>
</tr>
<tr>
<td>T8332XA</td>
<td>Displacement of intrauterine contraceptive device, initial encounter</td>
</tr>
<tr>
<td>T8339XA</td>
<td>Other mechanical complication of intrauterine contraceptive device, initial encounter</td>
</tr>
<tr>
<td>Z920</td>
<td>Personal history of contraception</td>
</tr>
<tr>
<td>Z30011</td>
<td>Encounter for initial prescription of contraceptive pills</td>
</tr>
<tr>
<td>Z30018</td>
<td>Encounter for initial prescription of other contraceptives</td>
</tr>
<tr>
<td>Z30019</td>
<td>Encounter for initial prescription of contraceptives, unspecified</td>
</tr>
<tr>
<td>Z3009</td>
<td>Encounter for other general counseling and advice on contraception</td>
</tr>
<tr>
<td>Z30430</td>
<td>Encounter for insertion of intrauterine contraceptive device</td>
</tr>
<tr>
<td>Z302</td>
<td>Encounter for sterilization</td>
</tr>
<tr>
<td>Z308</td>
<td>Encounter for other contraceptive management</td>
</tr>
<tr>
<td>Z3040</td>
<td>Encounter for surveillance of contraceptives, unspecified</td>
</tr>
<tr>
<td>Z3041</td>
<td>Encounter for surveillance of contraceptive pills</td>
</tr>
<tr>
<td>Z30431</td>
<td>Encounter for routine checking of intrauterine contraceptive device</td>
</tr>
<tr>
<td>Z3049</td>
<td>Encounter for surveillance of other contraceptives</td>
</tr>
<tr>
<td>Z3042</td>
<td>Encounter for surveillance of injectable contraceptive</td>
</tr>
<tr>
<td>Z3049</td>
<td>Encounter for surveillance of other contraceptives</td>
</tr>
<tr>
<td>Z308</td>
<td>Encounter for other contraceptive management</td>
</tr>
<tr>
<td>Z309</td>
<td>Encounter for contraceptive management, unspecified</td>
</tr>
<tr>
<td>Z310</td>
<td>Encounter for reversal of previous sterilization</td>
</tr>
<tr>
<td>Z3189</td>
<td>Encounter for other procreative management</td>
</tr>
<tr>
<td>Z3142</td>
<td>Aftercare following sterilization reversal</td>
</tr>
<tr>
<td>ICD-10</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>Z3161</td>
<td>Procreative counseling and advice using natural family planning</td>
</tr>
<tr>
<td>Z3169</td>
<td>Encounter for other general counseling and advice on procreation</td>
</tr>
<tr>
<td>Z9851</td>
<td>Tubal ligation status</td>
</tr>
<tr>
<td>Z9852</td>
<td>Vasectomy status</td>
</tr>
<tr>
<td>Z3181</td>
<td>Encounter for male factor infertility in female patient</td>
</tr>
<tr>
<td>Z3182</td>
<td>Encounter for Rh incompatibility status</td>
</tr>
<tr>
<td>Z3183</td>
<td>Encounter for assisted reproductive fertility procedure cycle</td>
</tr>
<tr>
<td>Z3184</td>
<td>Encounter for fertility preservation procedure</td>
</tr>
<tr>
<td>Z3189</td>
<td>Encounter for other procreative management</td>
</tr>
<tr>
<td>Z319</td>
<td>Encounter for procreative management, unspecified</td>
</tr>
<tr>
<td>Z975</td>
<td>Presence of (intrauterine) contraceptive device</td>
</tr>
</tbody>
</table>

The following is a list of self-referable family planning codes payable without prior authorization:

<table>
<thead>
<tr>
<th>HCPCS/CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1051</td>
<td>Medroxyprogesterone Injection</td>
</tr>
<tr>
<td>J1055</td>
<td>Medroxyprogesterone Acetate, 150 mg Injection</td>
</tr>
<tr>
<td>J1056</td>
<td>MA/EC Contraceptive Injection</td>
</tr>
<tr>
<td>11975</td>
<td>Norplant implant</td>
</tr>
<tr>
<td>11976</td>
<td>Norplant removal</td>
</tr>
<tr>
<td>11977</td>
<td>Removal with reinsertion, implantable contraceptive capsules</td>
</tr>
<tr>
<td>57170</td>
<td>Diaphragm fitting</td>
</tr>
<tr>
<td>58300</td>
<td>IUD insertion</td>
</tr>
<tr>
<td>58301</td>
<td>IUD removal only</td>
</tr>
<tr>
<td>58615</td>
<td>Occlusion of fallopian tubes by device (for example, band, clip, Falope ring), vaginal or suprapubic approach</td>
</tr>
<tr>
<td>81025</td>
<td>Pregnancy test</td>
</tr>
</tbody>
</table>

Professional Billing and Ancillary Claims

Hospital Readmission Policy

UniCare does not reimburse for readmission for a related condition if the member’s readmission occurs within seven days of discharge. These charges must be added to the original claim. UniCare may require medical records and review readmissions within 30 days of discharge to determine if the member was discharged early. Claims for readmissions within 30 days that are due to early discharge may be denied. This UniCare reimbursement policy is in line with the BMS reimbursement policy.

Professional Billing and Ancillary Claims

Immunizations Covered By Vaccines For Children

UniCare providers who administer vaccines to children 0-18 years of age must enroll in the VFC Program. UniCare will reimburse the administration fee for any vaccine available through the VFC Program. To enroll, call: 1-800-642-3634. Or complete the enrollment form online: www.dhhr.wv.gov/oeps/immunization/VFC.

When billing immunizations provided to you by the VFC Program, use the CMS-1500 claim form and do the following:

- In Box 24D, enter the appropriate CPT code with the SL modifier
- On another line of Box 24D, enter the appropriate administration procedure code (90471 through 90474)
- In Box 23, enter the PCP name

The following immunizations are covered under the VFC Program:  

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90620</td>
<td>Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use.</td>
</tr>
<tr>
<td>90621</td>
<td>Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use.</td>
</tr>
<tr>
<td>90633</td>
<td>Hepatitis A vaccine, pediatric/adolescent dosage, 2 dose schedule for intramuscular use.</td>
</tr>
<tr>
<td>90647</td>
<td>Hemophilus influenza B vaccine (Hib), PRP-OMP conjugate, 3 dose schedule for intramuscular use.</td>
</tr>
<tr>
<td>90648</td>
<td>Hemophilus influenza B vaccine (Hib), PRP-T conjugate, 4 dose schedule, for intramuscular use.</td>
</tr>
<tr>
<td>90649</td>
<td>Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 19, quadrivalent, 3 dose schedule, for intramuscular use.</td>
</tr>
<tr>
<td>90650</td>
<td>Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use.</td>
</tr>
<tr>
<td>90651</td>
<td>Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV).</td>
</tr>
<tr>
<td>90655</td>
<td>Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use.</td>
</tr>
<tr>
<td>90656</td>
<td>Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use.</td>
</tr>
<tr>
<td>90657</td>
<td>Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use.</td>
</tr>
<tr>
<td>90658</td>
<td>Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use.</td>
</tr>
<tr>
<td>90670</td>
<td>Pneumococcal conjugate vaccine, 13 valent, for intramuscular use.</td>
</tr>
<tr>
<td>90672</td>
<td>Influenza virus vaccine, quadrivalent, live, for intranasal use.</td>
</tr>
<tr>
<td>90680</td>
<td>Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use (Rotateq).</td>
</tr>
<tr>
<td>90681</td>
<td>Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use (Rotarix).</td>
</tr>
<tr>
<td>90685</td>
<td>Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use.</td>
</tr>
<tr>
<td>90686</td>
<td>Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use.</td>
</tr>
<tr>
<td>90688</td>
<td>Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use.</td>
</tr>
<tr>
<td>90696</td>
<td>Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 years through 6 years of age, for intramuscular use.</td>
</tr>
<tr>
<td>90698</td>
<td>Diphtheria, tetanus toxoids, acellular pertussis vaccine, hemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-HIB-IPV), for intramuscular use.</td>
</tr>
<tr>
<td>90700</td>
<td>diphtheria, tetanus toxoids, acellular pertussis vaccine (DtaP), when administered to individuals younger than 7 years, for intramuscular use.</td>
</tr>
<tr>
<td>90702</td>
<td>diphtheria and tetanus toxoids (DT), adsorbed when administered to individuals younger than 7 years, for intramuscular use.</td>
</tr>
<tr>
<td>90707</td>
<td>Measles, mumps, and rubella vaccine (MMR), live, for subcutaneous use.</td>
</tr>
<tr>
<td>90710</td>
<td>Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use.</td>
</tr>
<tr>
<td>90713</td>
<td>Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use.</td>
</tr>
<tr>
<td>90714</td>
<td>Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use.</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>90715</td>
<td>Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use</td>
</tr>
<tr>
<td>90716</td>
<td>Varicella virus vaccine, live, for subcutaneous use</td>
</tr>
<tr>
<td>90723</td>
<td>Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use</td>
</tr>
<tr>
<td>90732</td>
<td>Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use</td>
</tr>
<tr>
<td>90734</td>
<td>Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use (Menactra)</td>
</tr>
<tr>
<td>90744</td>
<td>Hepatitis B vaccine, pediatric/adolescent dosage; 3 dose schedule, for intramuscular use.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SL</td>
<td>Members of high-risk population</td>
</tr>
</tbody>
</table>

**Professional Billing and Ancillary Claims**

**Immunization Administration Procedures Covered Under the VFC Program**

The following are the vaccine administration procedures and their billing codes:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Immunization administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>90471</td>
<td>1 vaccine, single or combination vaccine/toxoid</td>
<td>Includes percutaneous, intradermal, subcutaneous or intramuscular injections</td>
</tr>
<tr>
<td>90472</td>
<td>Each addition vaccine, single or combination vaccine/toxoid. List separately from the code for primary procedure</td>
<td>Includes percutaneous, intradermal, subcutaneous or intramuscular injections</td>
</tr>
<tr>
<td>90473</td>
<td>1 vaccine, single or combination vaccine/toxoid</td>
<td>Immunization administration includes intranasal or oral route</td>
</tr>
<tr>
<td>90474</td>
<td>Each addition vaccine, single or combination vaccine/toxoid. List separately from the code for primary procedure</td>
<td>Immunization administration includes intranasal or oral route</td>
</tr>
</tbody>
</table>

**Professional Billing and Ancillary Claims**

**Immunizations Not Covered By Vaccines for Children**

When billing for immunizations not covered by the VFC Program, use the CMS-1500 claim form and do the following:

- On a line of Box 24D, enter the appropriate CPT code
- On another line of Box 24D, enter the appropriate administration procedure code

Please note: The SL modifier is not required.

**Professional Billing and Ancillary Claims**

**Additional Services during EPSDT Exams**

If a member is evaluated and treated for a problem during the same visit as an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) annual exam or well-child visit, the problem-oriented exam may be billed separately if accompanied by the modifier 25. The problem must require an additional, moderate-level evaluation to qualify as a separate service on the same date. Use modifier 25 only if documenting a distinct, separately identifiable reason for the visit in the member’s record.
Maternity Services

UniCare requires itemization of maternity services when submitting claims for reimbursement. Please use the CMS-1500 claim form with the appropriate CPT, HCPCS codes and ICD diagnosis codes. Include the applicable Evaluation and Management (E&M) code, as well as coding for all other procedures performed.

Maternity billing guidelines are as follows:

- UniCare reimburses one delivery or cesarean section procedure per member in a seven-month period. Reimbursement includes multiple births.
- Delivering providers who perform regional anesthesia or nerve block may not receive additional reimbursement. Regional anesthesia and nerve block charges are included in the reimbursement for the delivery.
- UniCare reimburses anesthesia services and delivery at full allowance when rendered by the delivering provider.
- When billing UniCare, itemize each service individually and submit claims as the services are rendered. The filing deadline will be applied to each individual date of service submitted.
- Bill the laboratory and radiology services provided during pregnancy separately, including pregnancy tests. UniCare must receive these claims within 180 days from the date of service.
- Use of the appropriate E&M or CPT codes is necessary for appropriate reimbursement. Indicate the Estimated Date of Confinement (EDC) in Box 24D of the CMS-1500 claim form.
- If a member is admitted to the hospital during the course of her pregnancy, the diagnosis necessitating the admission should be the primary diagnosis on the claim.
- If a pregnancy is high-risk, document the high-risk diagnosis on the claim form.
- Identify the nature of a high-risk care visit in the diagnosis field in Box 21 of the CMS-1500 claim form or in another appropriate field.
- Use the CMS-1500 claim form with itemized E&M codes.
- For professional claims only, include the date of the member’s last menstrual period.
- Use CPT code 99213 with the TH modifier to bill for each prenatal visit. UniCare requires modifier 25 along with 99213-TH when the member has an office visit on the same date of service as an ultrasound (76801, 76802, 76805-76828) or fetal non-stress test (59025) in the provider’s office. Use modifier 25 only if you document a distinct, separately identifiable reason for the visit in the member’s record.
- Submit pregnancy notification to UniCare within seven days of the first prenatal visit or as soon as possible thereafter. Use the Pregnancy Risk Screening Instrument (PRSI) form, available in the Forms and Tools section of the Provider Resources page of our website at www.unicare.com. Completed forms can be emailed to prsi.unicare@anthem.com with “SECURE PRSI” in the subject line or faxed to 1-877-833-5729. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

For information about billing for termination of pregnancy, hysterectomy and sterilization, refer to the appropriate sections of Chapter 10: Billing Institutional Claims: Termination of Pregnancy, Hysterectomy, or Sterilization.
The following are the billing codes for maternity services:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59409</td>
<td>Vaginal delivery only (with or without episiotomy and/or forceps)</td>
</tr>
<tr>
<td>59412</td>
<td>External cephalic version, with or without tocolysis</td>
</tr>
<tr>
<td>59414</td>
<td>Delivery of placenta (separate procedure)</td>
</tr>
<tr>
<td>59514</td>
<td>Cesarean section only</td>
</tr>
<tr>
<td>59612</td>
<td>Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)</td>
</tr>
<tr>
<td>59620</td>
<td>Cesarean section only, following attempted vaginal delivery after previous cesarean delivery</td>
</tr>
</tbody>
</table>

**Professional Billing and Ancillary Claims**

**Maternity Services: Codes for Prenatal, Deliveries and Postpartum Services**

Initial prenatal care visits are payable with the CPT code 99213, indicating an office/outpatient visit, established — Moderate severity. In addition, you must include a TH modifier, indicating an obstetrical treatment/service.

Postpartum care is payable with CPT code 59430, between day 21 and 56, indicating Postpartum Care Only.

**Professional Billing and Ancillary Claims**

**Maternity Services: Cesarean Sections**

Medicaid restricts any Cesarean section, labor induction or any delivery following labor induction to the following criteria:

- Gestational age of the fetus should be determined to be at least 39 weeks or fetal lung maturity must be established before delivery.
- When the delivery occurs prior to 39 weeks, maternal and/or fetal conditions must dictate medical necessity for the delivery.

Any Cesarean section, labor induction, or delivery that follows labor induction and that occurs prior to 39 weeks of gestation will be denied if the procedure is considered to be not medically necessary. Records will be subject to retrospective review. If a Cesarean section, labor induction, or delivery following labor induction fails to meet the criteria for medical necessity, payments made will be subject to recoupment. Recoupment may apply to all services related to the delivery, including additional provider and hospital fees.

**Professional Billing and Ancillary Claims**

**Maternity Services: Newborns**

Submit newborn claims using either the Medicaid ID number of the mother or the West Virginia-issued Medicaid ID number of the newborn. Do not use a temporary ID number, which is an ID ending in NB followed by one or more digits. UniCare rejects claims with temporary ID numbers. Providers may bill using the mother’s Medicaid ID number:

- During the month of birth and up to an additional 60 days after the baby is born or
- Until the newborn is assigned his or her own UniCare Medicaid ID number
Also submit the name, date of birth and other pertinent information about the newborn on a Newborn Enrollment Notification Report. To prevent any delay in UniCare coverage for newborns, perform the following:

- Notify UniCare of all deliveries within 3 days of delivery. Use the Newborn Enrollment Notification Report found in the Forms and Tools section of the Provider Resources page of our website at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.
- Notify UniCare when you receive a newborn’s permanent Medicaid ID number. Use the Newborn Enrollment Notification Report found on the UniCare website at www.unicare.com.

Request that your patients take these important steps as soon as their babies are born:

- Immediately contact the West Virginia BMS or their Social Worker to request the required paperwork.
- Fill out and return the required paperwork to BMS to enroll their newborn in Medicaid.

Hospitals should bill for newborn delivery and other newborn services on a separate claim from the services they provide to the mother.

**Professional Billing and Ancillary Claims**

**Newborns: Circumcision**

All circumcisions performed on members more than 30 days after birth require authorization from UniCare’s Utilization Management department and are subject to medical necessity. Circumcision charges should be billed with appropriate CPT codes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>54150</td>
<td>Circumcision, Using Clamp Or Other Device – Newborn</td>
</tr>
<tr>
<td>54152</td>
<td>Circumcision, Using Clamp Or Other Device – Except Newborn</td>
</tr>
<tr>
<td>54160</td>
<td>Circumcision, Surgical Excision Other Than Clamp, Device or Dorsal Split – Newborn</td>
</tr>
<tr>
<td>54161</td>
<td>Circumcision, Surgical Excision Other Than Clamp, Device or Dorsal Split – Except Newborn</td>
</tr>
</tbody>
</table>

**Professional Billing and Ancillary Claims**

**Billing Members for Services Not Medically Necessary**

Providers may bill a UniCare member for a service that is not medically necessary if all of the following conditions are met:

- The member requests a specific service or item that, in your opinion, may not be reasonable or medically necessary.
- The member requests a specific service or item that, in UniCare’s opinion, may not be reasonable or medically necessary.
- The provider obtains a written acknowledgement to verify that the member was notified of financial responsibility for the services rendered.
- The member signs and dates the acknowledgement to accept responsibility to pay for the requested service.
Professional Billing and Ancillary Claims

Private Pay Agreement
Providers may bill a member for a requested service without a signed acknowledgement if the service is not a covered benefit and if the following conditions are met:

- Inform the member that the requested service is not a UniCare covered benefit.
- Notify the member of his or her financial responsibility.
- Accept the member as a private pay patient.
- Advise the member that he or she:
  - Has been accepted as a private pay patient at the time of service.
  - Will be responsible for the cost of all services received.

UniCare strongly encourages providers to obtain an acknowledgement of the notification in writing.

Professional Billing and Ancillary Claims

On-Call Services
On-call services may be billed when the rendering physician is not the PCP but is covering for or has received permission from the PCP to provide service that day. Enter On-Call for PCP in Box 23 of the CMS-1500 claim form.

Professional Billing and Ancillary Claims

Recommended Fields for the CMS-1500 Claim Form
All professional providers and vendors should bill UniCare using the most current version of the CMS-1500 claim form. The following field descriptions will assist in completing the CMS-1500 claim form. The letter M indicates a mandatory field.

<table>
<thead>
<tr>
<th>Field</th>
<th>Title</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 1</td>
<td>Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan W, FECA Blk Lung, Other ID</td>
<td>If the claim is for Medicaid, put an “X” in the Medicaid box. If the Member has both Medicaid and Medicare, put an X in both boxes. Attach a copy of the form submitted to Medicare to the claim.</td>
</tr>
<tr>
<td>Field 1a (M)</td>
<td>Member’s ID Number</td>
<td>Use the Member’s UniCare (Medicaid) ID number (Recipient Identification [RID] Number), .</td>
</tr>
<tr>
<td>Field 2 (M)</td>
<td>Member’s Name</td>
<td>Enter the last name, first name, and middle initial, if known, in that order. Do not use nicknames or full middle names.</td>
</tr>
<tr>
<td>Field 3 (M)</td>
<td>Member’s Birth Date/Sex</td>
<td>Date of birth format: MM/DD/YYYY. For example, write September 1, 1963, as 09/01/1963. Check the appropriate box for the patient’s sex.</td>
</tr>
<tr>
<td>Field 4 (M)</td>
<td>Insured’s Name</td>
<td>“Same” is acceptable if the insured is the patient.</td>
</tr>
<tr>
<td>Field 5 (M)</td>
<td>Member’s Address/Telephone</td>
<td>Enter complete address and phone number, including any unit or apartment number. Abbreviations for road, street, avenue, boulevard, place or other common ending to the street name are acceptable.</td>
</tr>
<tr>
<td>Field 6 (M)</td>
<td>Patient Relationship to Insured</td>
<td>Enter the patient’s relationship to the Member or subscriber.</td>
</tr>
<tr>
<td>Field 7 (M)</td>
<td>Insured’s Address</td>
<td>“Same” is acceptable if the insured is the patient.</td>
</tr>
<tr>
<td>Field</td>
<td>Title</td>
<td>Explanation</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Field 8 (M)</td>
<td>Member Status</td>
<td>Check Single, Married or Other for marital status. If applicable, check Employed, Full-Time Student or Part-Time Student.</td>
</tr>
<tr>
<td>Field 9 (M)</td>
<td>Other Insured’s Name</td>
<td>If there is insurance coverage in addition to the Member’s Plan coverage, enter the name of the insured.</td>
</tr>
<tr>
<td>Field 9a (M)</td>
<td>Other Insured's Policy or Group Number</td>
<td>Referring to Field 9, enter the name of the insurance with the group and policy number.</td>
</tr>
<tr>
<td>Field 9b (M)</td>
<td>Other Insured's Date of Birth</td>
<td>Referring to Field 9, enter the date of birth in the following format: MM/DD/YYYY.</td>
</tr>
<tr>
<td>Field 9c (M)</td>
<td>Employer’s or School Name</td>
<td>Referring to Field 9, enter the name of other insured's employer or school.</td>
</tr>
<tr>
<td>Field 9d (M)</td>
<td>Insurance Plan Name or Program Name</td>
<td>Referring to Field 9, enter the name of plan carrier.</td>
</tr>
<tr>
<td>Field 10 (M)</td>
<td>Patient’s Condition Related To</td>
<td>Include any description of injury or accident and whether it occurred at work or not.</td>
</tr>
<tr>
<td>Field 10a (M)</td>
<td>Related to Employment?</td>
<td>Y or N. If insurance is related to Workers’ Compensation, enter Y.</td>
</tr>
<tr>
<td>Field 10b (M)</td>
<td>Related to Auto Accident/Place?</td>
<td>Y or N. Enter the state in which the accident occurred.</td>
</tr>
<tr>
<td>Field 10c (M)</td>
<td>Related to Other Accident?</td>
<td>Y or N.</td>
</tr>
<tr>
<td>Field 10d (M)</td>
<td>Reserved for local use</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Field 11 (M)</td>
<td>Insured’s Policy Group or FECA Number</td>
<td>Insured’s group number. Complete information about the insured, even if the same as the patient.</td>
</tr>
<tr>
<td>Field 11a (M)</td>
<td>Insured’s Date of Birth/Sex</td>
<td>Date of birth format: MM/DD/YYYY. Sex: M or F.</td>
</tr>
<tr>
<td>Field 11b (M)</td>
<td>Employer’s Name or School Name</td>
<td>Name of the organization from which the insured obtained the policy.</td>
</tr>
<tr>
<td>Field 11c (M)</td>
<td>Insurance Plan Name or Program Name</td>
<td>Plan carrier / EP1 benefit code for paper claims.</td>
</tr>
<tr>
<td>Field 11d (M)</td>
<td>Is There Another Health Benefit Plan?</td>
<td>Y or N. If Yes, items 9A-9D must be completed.</td>
</tr>
<tr>
<td>Field 12</td>
<td>Patient’s or Authorized Person’s Signature</td>
<td>Signature and date. “Signature on file”, indicating that the appropriate signature was obtained by the Provider, is acceptable for this field.</td>
</tr>
<tr>
<td>Field 13</td>
<td>Member’s or Authorized Person’s Signature</td>
<td>Signature. “Signature on file” is acceptable for this field.</td>
</tr>
<tr>
<td>Field 14 (M)</td>
<td>Date of Current</td>
<td>Circle Injury, Illness or Pregnancy (if applicable) and enter the date.</td>
</tr>
<tr>
<td>Field 15</td>
<td>First Date</td>
<td>Date of first consultation for the patient’s condition. Date format: MM/DD/YYYY</td>
</tr>
<tr>
<td>Field 16</td>
<td>Dates Patient Unable to Work in Current Occupation (From – To)</td>
<td>Date format: MM/DD/YYYY</td>
</tr>
<tr>
<td>Field 17 (M)</td>
<td>Name of Referring Physician or Other Source</td>
<td>Name of Physician, clinic or facility referring the patient to the Provider.</td>
</tr>
<tr>
<td>Field 17a (M)</td>
<td>Blank</td>
<td>Field intentionally left blank. The provider ID of the referring physician. Note: 17a is not to be reported. However, 17b must be reported when a service was ordered or referred by a provider.</td>
</tr>
<tr>
<td>Field</td>
<td>Title</td>
<td>Explanation</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Field 17b (M)</td>
<td>NPI</td>
<td>Use the referring Provider NPI. FQHCs, health departments, West Virginia health centers, urgent care clinics and diagnostic specialists are not required to include the referring provider’s NPI.</td>
</tr>
<tr>
<td>Field 18</td>
<td>Hospitalization Dates Related to Current Services (From – To)</td>
<td>Date format: MM/DD/YYYY</td>
</tr>
<tr>
<td>Field 19 (M)</td>
<td>Reserved for Local Use</td>
<td>For multiple transfers, indicate that the claim is part of a multiple transfer and provide the other client’s complete name and Medicaid number. Provide information about the accident, including the date of occurrence, how the accident happened, whether the accident was self-inflicted or employment-related.</td>
</tr>
<tr>
<td>Field 20</td>
<td>Outside Lab? (Yes or No) and the $ Charge</td>
<td>Enter the appropriate information if lab services were sent to an outside lab.</td>
</tr>
<tr>
<td>Field 21 (M)</td>
<td>Diagnosis or Nature of Illness or Injury</td>
<td>Enter the appropriate diagnosis code or nomenclature. Check the CPT manual or ask a coding expert if you are not certain of what to enter.</td>
</tr>
<tr>
<td>Field 22</td>
<td>Medicaid Resubmission</td>
<td>Under “Original Ref. No.” enter the 17-digit transaction control number (TCN) associated with any claim being resubmitted that is older than 1 year (365 days). If additional space is needed, use Box 19.</td>
</tr>
<tr>
<td>Field 23</td>
<td>Prior Authorization Number</td>
<td>Enter authorization information in this field, such as a pre-service review, reference number or on-call Physician for the PCP.</td>
</tr>
<tr>
<td>Field 24A (M)</td>
<td>Date(s) of Service</td>
<td>If dates of service cross over from 1 year to the next year, submit 2 separate claims. For example, 1 claim is for services in 2012, while another claim is for services in 2013. Itemize each date of service on the claim; avoid spanning dates.</td>
</tr>
<tr>
<td>Field 24B (M)</td>
<td>Place of Service</td>
<td>Enter a 2-digit code using current coding from the CPT manual.</td>
</tr>
<tr>
<td>Field 24C</td>
<td>EMG</td>
<td>Enter the appropriate condition indicator for medical checkups, if applicable.</td>
</tr>
<tr>
<td>Field 24D (M)</td>
<td>Procedure, Services or Supplies</td>
<td>Enter the appropriate CPT codes or nomenclature. Indicate appropriate modifier when applicable. Do not use “not otherwise classified” (NOC) codes unless there is no specific CPT code available. If you use an NOC code, include a narrative description.</td>
</tr>
<tr>
<td>Field 24E (M)</td>
<td>Diagnosis Pointer</td>
<td>Use the most specific ICD code available.</td>
</tr>
<tr>
<td>Field 24F (M)</td>
<td>Dollar Charges</td>
<td>Enter the charge for each single line item.</td>
</tr>
<tr>
<td>Field 24G (M)</td>
<td>Days or Units</td>
<td>The quantity of services for each itemized line. For anesthesia, the actual time of the service rendered, in minutes.</td>
</tr>
<tr>
<td>Field 24H</td>
<td>EPSDT Family Plan</td>
<td>Indicate if the services were the result of a checkup or a family planning referral.</td>
</tr>
<tr>
<td>Field 24I (M)</td>
<td>ID. Qual. / NPI</td>
<td>Enter your NPI, if available. NPI is required for electronic claims and we strongly encourage you to use your NPI number for paper claims.</td>
</tr>
<tr>
<td>Field</td>
<td>Title</td>
<td>Explanation</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Field 24J (M)</td>
<td>Rendering Provider ID. #</td>
<td>Enter the rendering Provider’s NPI in the unshaded portion and enter the rendering taxonomy code in the shaded portion.</td>
</tr>
<tr>
<td>Field 25 (M)</td>
<td>Federal Tax ID Number</td>
<td>Enter the 9-digit number from your W-9.</td>
</tr>
<tr>
<td>Field 26 (M)</td>
<td>Patient’s Account Number</td>
<td>This field is for the Provider’s use in identifying patients and allows use of up to 9 numbers or letters (no other characters are allowed).</td>
</tr>
<tr>
<td>Field 27 (M)</td>
<td>Accept Assignment?</td>
<td>All Providers of Medicaid services must check YES.</td>
</tr>
<tr>
<td>Field 28 (M)</td>
<td>Total Charge</td>
<td>Enter the total charge for each single line item.</td>
</tr>
<tr>
<td>Field 29 (M)</td>
<td>Amount Paid</td>
<td>Enter any payment that has been received for this claim.</td>
</tr>
<tr>
<td>Field 30 (M)</td>
<td>Balance Due</td>
<td>Must equal the amount in Box 28, less the amount in Box 29.</td>
</tr>
<tr>
<td>Field 31 (M)</td>
<td>Signature of Physician or Supplier, Including Degrees or Credentials</td>
<td>Actual signature or typed/printed designation is acceptable.</td>
</tr>
<tr>
<td>Field 32 (M)</td>
<td>Service Facility Location Information</td>
<td>Include any suite or office number. Abbreviations for road, street, avenue, boulevard, place or other common ending to the street name are acceptable.</td>
</tr>
<tr>
<td>Field 32A (M)</td>
<td>Blank</td>
<td>Field intentionally left blank. Enter the NPI of the service facility, as soon as the NPI is available.</td>
</tr>
<tr>
<td>Field 33 (M)</td>
<td>Billing Provider Info and Phone #</td>
<td>Provider name, NPI, street, city, state, ZIP code and telephone number.</td>
</tr>
<tr>
<td>Field 33A (M)</td>
<td>Blank</td>
<td>Field intentionally left blank. Enter the NPI number.</td>
</tr>
<tr>
<td>Field 33B (M)</td>
<td>Blank</td>
<td>Field intentionally left blank. Enter the NPI number of the billing Provider.</td>
</tr>
</tbody>
</table>
Billing Institutional Claims

Overview
Billing for hospitals and other health care facilities and services may require special attention because major services have their own set of billing requirements. Throughout this chapter, specific billing requirements will be broken down into the following service areas:

- Emergency room visits
- Urgent care visits
- Maternity
- Termination of pregnancy
- Inpatient acute care
- Hospital stays of less than 24 hours
- Inpatient sub-acute care
- Outpatient laboratory, radiology and diagnostic services
- Outpatient surgical services
- Outpatient therapies
- Outpatient infusion therapy visits and pharmaceuticals

Also included are helpful billing guidelines for the ancillary services that network providers use most often, including diagnostic imaging. These ancillary services include the following:

- Ambulance services
- Ambulatory surgical centers
- Dialysis
- Durable medical equipment (DME)
- Home health care
- Home infusion therapy
- Hospice
- Laboratory and diagnostic imaging
- Physical, speech and occupational therapy
- Skilled nursing facilities

Please note: A member’s benefits may not cover some of these services; confirm coverage before providing service.

And finally, this chapter will take a look at specific coding guidelines for the standard hospital and health care facilities’ CMS-1450 claim form.
Basic Billing Guidelines

In general, the basic billing guidelines for institutional claims submitted to UniCare are as follows:

- Use Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) or revenue codes. Valid HCPCS, CPT or revenue codes are required for all line items billed, whether sent on paper or electronically.
- Split year-end claims. Services that begin before or during December and extend beyond December 31 should be billed as a split claim at calendar year-end. Use two CMS-1450 claim forms and submit the forms together.
- Split dates of service for a provider contract change. When a provider contract change occurs during the course of treatment, split the dates of service to be reimbursed at the new rate.
- Itemize services. Service itemization is required when the “From” and “Through” service dates are the same.
- Provide medical records. Medical records for certain procedures may be requested for determination of medical necessity.
- Use modifiers in accordance with your specific billing instructions.
- Use codes for unlisted procedures. Because some provider services or procedures are not found in the CPT manual, specific code numbers for reporting unlisted procedures have been designated. When using an unlisted procedure code, include a description of the service to help us calculate the appropriate reimbursement. We may request the member’s medical records.
- Complete the appropriate billing for supplies and materials. Do not use CPT code 99070, which is for supplies and materials provided over and above those usually included with an office visit or other services. UniCare does not accept CPT code 99070. In addition:
  - Health care providers must use HCPCS Level II codes, which provide a detailed description of the service.
  - UniCare will pay for surgical trays only for specific surgical procedures. Surgical trays billed with all other services will be considered incidental and will not be paid separately.

Please note: System edits are in place for both electronic and paper claims. Claims submitted improperly cannot be processed easily and most likely will be returned.

National Drug Codes

Providers must include national drug codes (NDCs), unit of measurement and quantity of drug on all UniCare claims that include physician-administered drugs. This applies to drugs dispensed in both professional and institutional outpatient settings.

West Virginia’s Bureau for Medical Services (BMS) requires that UniCare report NDC information every month. BMS then submits this data to pharmaceutical manufacturers to obtain rebates under the Medicaid Drug Rebate Program. Following these instructions is important for the state to receive timely rebates from drug manufacturers.

UniCare will deny professional and outpatient institutional claims containing physician-administered medications for UniCare members if any of the following elements are missing or invalid:

- NDCs (11-digit number on the package or container from which medication is administered)
- Unit of measurement
Quantity of drug

Billing Institutional Claims
Emergency Room Visits

The billing requirements for an emergency room visit apply to the initial treatment of a medical or psychiatric emergency, but only if the patient does not remain overnight. If the emergency room visit results in an admission, all services provided in the emergency room must be billed according to the guidelines and requirements for inpatient acute care.

Reimbursement for emergency room services relates to the nature of the emergency diagnosis. There are five CPT procedure codes available for billing emergency room services. The reimbursement is an all-inclusive fee, which is considered to include the following items:

- Use of emergency room
- Routine supplies (such as sterile dressings)
- Minor supplies (bandages, slings, finger braces, etc.)
- Pharmacy charges
- Suture, catheter, and other trays
- IV fluids and supplies
- Routine EKG monitoring
- Oxygen administration and $O_2$ saturation monitoring

Diagnostic procedures including lab and radiology may be billed separately and in addition to the emergency room services.

UniCare will not reimburse providers for services rendered in an emergency room for the treatment of conditions that do not meet the prudent layperson standard as an emergency medical condition. The exceptions to this requirement are:

- UniCare will reimburse the physician screening fee and facility fee even if the condition is not an emergency
- UniCare will reimburse if either of the following criteria are met:
  - The services were authorized by UniCare
  - The PCP referred the member for treatment

UniCare reviews emergency services claims to determine appropriate use of the emergency room and whether an emergency medical condition existed. At a minimum, both the facility and the physician will receive reimbursement for screening services:

- All ER claims must include clinical documentation.
- ER claims submitted without clinical documentation will be processed at the payment level of CPT code 99282.
- ER claims submitted with clinical documentation and not meeting the prudent layperson standard will be processed at the payment level of CPT code 99282.
- ER claims submitted with clinical documentation and meeting the prudent layperson standard will be processed at the payment level of the CPT code submitted.
Specific coding is required for emergency room billing. Use the following guidelines:

- Bill each service date as a separate line item.
- Perform a screening examination on the Member.
- Use the five appropriate CPT codes for emergency room billing.
- Use International Classification of Diseases (ICD) principal diagnosis codes, as required, for all services provided in an emergency room setting.
- Use revenue codes 0450-0452 and 0459, as required.

Please note: Unless clinically required, follow-up care should never occur in the emergency department. Members should be referred back to their PCP and correct billing should follow standard, nonemergency guidelines.

Emergency room billing does not apply when the member is admitted and treated for inpatient care following emergency room treatment.

Billing Institutional Claims

Urgent Care Visits

The billing requirements for urgent care visits apply to all urgent care cases treated and discharged from the hospital outpatient department or emergency room.

Urgent care: Nonscheduled, nonemergency hospital services required to prevent serious deterioration of a patient’s health as a result of an unforeseen illness or injury.

Urgent care billing should detail all diagnostic and therapeutic services, including, but not limited to:

- Equipment
- Facility use, including nursing care
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the visit

Urgent care billing does not apply when the member is admitted and treated for inpatient care following urgent care treatment.

Specific coding is required for urgent care billing. Use the following guidelines:

- Bill each service date as a separate line item.
- Use current ICD principal diagnosis codes, as required, for all services provided in an urgent care setting or designated facility.

Please note: Urgent care billing does not apply when the member is admitted and treated for inpatient care following urgent care treatment. If the member is admitted following urgent care, the billing shifts to acute or subacute care.
Billing Institutional Claims

Observation
Observation is billed using Revenue Codes 760 and 762 and time units reported in one-hour increments. The maximum number of units allowed for an episode of care is 48.

Observation is defined as “the use of a bed and periodic monitoring by hospital nursing or other staff which are reasonable and necessary to evaluate an outpatient’s condition to determine the need for inpatient admission.”

The criteria for observation services include the following basic provisions:
- Observation services are covered only upon written order of a physician. This order must document the medical necessity for the services and is retained as part of the patient’s medical record
- Observation does not require prior authorization
- Coverage of observation may not exceed 48 hours
- Charges for observation services which result in an inpatient admission are deemed to be part of the admission and not separately billable
- Ancillary services, laboratory, X-ray and other diagnostic procedures performed during the observation period may be billed separately and are subject to all prior authorization criteria

Billing Institutional Claims

Maternity Services
The billing requirements for maternity care apply to all live and stillbirth deliveries. Payment for services includes, but is not limited to, the following:
- Room and board for mother, including nursing care
- Nursery for baby, including nursing care
- Delivery room/surgical suites
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Other services incidental to admission

The maternity care rate covers the entire admission. If an admission is approved for extension beyond the contracted time limit for continuous inpatient days, the billing requirement for the entire admission shifts to inpatient acute care. This applies to each approved and medically necessary service day. Therapeutic abortions, treatment for ectopic and molar pregnancies and similar conditions are excluded from payment under the maternity care rate.

Inpatient maternity claims must be authorized if the maternity stay exceeds either 1) 48 hours post-delivery for vaginal delivery or 2) 96 hours post-delivery for C-section delivery.

Billing Institutional Claims

Hysterectomy
Providers must include the Hysterectomy Acknowledgement Form in the member’s medical records. The provider’s signature must be original script, not stamped or typed. Providers do not need to submit the
form with the claim. The form is available on the state’s website at: https://www.wvmmis.com/Forms/Forms/AllItems.aspx.

Billing Institutional Claims
Sterilization
Providers must include the Sterilization Consent Form in the member’s medical records. The provider’s signature must be original script, not stamped or typed. Providers do not need to submit the form with the claim. The form is available on the state’s website at: https://www.wvmmis.com/Forms/Forms/AllItems.aspx.

Billing Institutional Claims
Inpatient Acute Care
The billing requirements for inpatient acute care apply to each approved and medically necessary service day in a licensed bed. These requirements include, but are not limited to:

- Room and board, including nursing care
- Emergency room, if connected to admission
- Urgent care, if connected to admission
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Surgical and recovery suites
- Other services incidental to the admission

Please note: Prior authorization is required for all admissions except standard vaginal delivery and term Cesarean sections.

Special billing requirements:

- The facility must be a West Virginia BMS facility.
- Utilization Management department approval is required for all admissions except routine deliveries.
- Observation room, or outpatient billing with an inpatient stay, should be completed on the CMS-1450 claim form. Complete the “From” box of Form Locator 6 (FL 6) and Form Locator 17 (FL 17) correctly to ensure the claim is processed. Note the following requirements:
  - Ensure the dates reported in (FL 6) and (FL 17) are the same.
  - Verify the charges in (FL 6) and (FL 17) reflect the date the patient was admitted as an inpatient to the hospital.
  - Do not use (FL 6) and (FL 17) to include the date of any observation stay or outpatient charges that occurred prior to inpatient admission. This usage is incorrect and may cause processing delays.
Billing Institutional Claims

Billing for Hospital Stays of Less Than 24 Hours

Inpatient claims with next day discharge are assumed to be less than 24 hours if you do not provide medical records to the contrary. If you submit a claim for inpatient stays with the “through date” of service as being one day later than the “from date” of service, this claim will be subject to post-payment review.

When submitting a claim for a hospital stay of less than 24 hours, bill the claim as an Outpatient Hospital Services claim and follow these guidelines:

- Service codes: Include the correct CPT/HCPCS code for each service.
- Line items: Bill each service for each date as a separate line item.
- Revenue codes: Bill the revenue codes with the appropriate CPT/HCPCS codes.
- Type of bill: Enter the type of bill as 13X.
- Admission and discharge dates: Ensure these dates are not the same. If a patient is transferred out within 24 hours of admission, bill this visit as an outpatient claim.
- Discharge date: Ensure the discharge date is not the day following admission. If a patient is transferred out within 24 hours of admission, bill this visit as an outpatient claim.

A claim submitted for a stay of less than 24 hours will be denied.

Please note: These criteria do not apply to neonatal claims, which are one-day stays falling under the following diagnosis-related groups (DRGs):

- DRG 637: Neonate, died within one day of birth, born here
- DRG 638: Neonate, died within one day of birth, not born here
- DRG 639: Neonate, transferred less than five days old, born here
- DRG 640: Neonate, transferred less than five days old, not born here

Billing Institutional Claims

Inpatient Subacute Care

The billing requirements for inpatient, subacute care include each approved and medically necessary service day in a licensed and accredited facility at the appropriate level of care.

Subacute care: Includes levels of inpatient care less intensive than those required in an inpatient acute care setting.

Each inpatient, subacute care admission is considered a separate admission from any preceding or subsequent acute care admission and should be billed separately.

Covered services include, but are not limited to:

- Room and board, including nursing care
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the admission

Please note: All subacute admissions require prior authorization and a treatment plan.
The treatment plan must accompany the admission and include:

- Functional, reasonable, objective and measurable goals within a predictable time frame for each skilled discipline
- A discharge plan and customized options, identified and implemented from the admission date
- Weekly summaries for each discipline
- Biweekly conference reports

**Billing Institutional Claims**

**Outpatient Laboratory, Radiology and Diagnostic Services**

Specific billing requirements for services related to outpatient laboratory, pathology, radiology and other diagnostic tests include, but are not limited to:

- Facility use
- Nursing care, including incremental nursing
- Equipment
- Professional services
- Specified supplies
- All other services incidental to the outpatient visit

**Please note:** Outpatient radiation therapy is excluded from this service category and should be billed according to the requirements of the Other Services category.

**Billing Institutional Claims**

**Outpatient Surgical Services**

Specific billing requirements related to outpatient surgical services include, but are not limited to:

- Facility use, including nursing care
- Blood
- Equipment
- Imaging services
- Implantable prostheses
- Laboratory
- Pharmaceutical
- Radiology
- Supplies
- All other services incidental to the outpatient surgery visit

**Please note:** Even if a service is classified by the hospital as an outpatient service, if the member is receiving that service as of midnight (12 a.m.), bill the service at the inpatient DRG rate.

Specific dates, codes and medical records may be required for billing:

- Follow the billing requirements for outpatient surgery when the respiratory therapy department performs an electrocardiogram (ECG/EKG) or electroencephalogram (EEG). Do not apply the outpatient therapy billing requirements.
- Include service dates for each procedure (both principal and other).
- Include CPT/HCPCS codes for each surgical procedure in Form Locator 44 (HCPCS/RATES).
- Provide medical records when UniCare needs to review and determine the correct grouping for services not defined in the surgery grouping.
- Use billing field entry 13X.
• Use revenue codes 036X, 0480, 0481, 0490, 070X, 071X, 075X, 076X, 079X and 0975, as required, along with the appropriate CPT/HCPCS code.
• Use the CPT/HCPCS code, as mandated by HIPAA, for outpatient surgery billing.

Billing Institutional Claims

Outpatient Therapies

Outpatient therapy services include physical, occupational, speech and respiratory therapies. An outpatient therapy visit has a single service date. Billing requirements for outpatient therapy visits include, but are not limited to:
• Facility use, including nursing care
• Therapist/professional services
• Equipment
• Pharmaceuticals
• Supplies
• Other services incidental to the outpatient therapy visit

Billing for outpatient therapy has specific requirements:
• Bill each service date as a separate line item.
• Use the required revenue codes:
  o Occupational therapy: 043X
  o Physical therapy: 042X
  o Respiratory therapy: 041X
  o Speech therapy: 044X
• Use the applicable CPT/HCPCS codes, as required.

Billing Institutional Claims

Outpatient Infusion Therapies and Pharmaceuticals

This section covers the following topics:
• Outpatient infusion therapies
• Outpatient infusion pharmaceuticals

Outpatient Infusion Therapies

Billing requirements for outpatient infusion therapy visits apply to each outpatient hospital visit and include, but are not limited to:
• Facility use, including nursing care
• Equipment
• Intravenous solutions, excluding pharmaceuticals
• Kinetic dosing
• Laboratory
• Professional services
• Radiology
• Supplies, including syringes, tubing, line insertion kits, etc.
• Other services incidental to the outpatient infusion therapy visit
Outpatient Infusion Pharmaceuticals
Billing requirements for outpatient infusion pharmaceuticals apply to drugs such as chemotherapy, hydration and antibiotics used during each outpatient infusion therapy visit. An important exception is for blood and blood products, which are billed under the Other Services category.
Specific codes and service dates are required:
• Use revenue codes 026X, 028X, 0331, 0335 or 0940, as required, for each outpatient infusion therapy visit.
• Use revenue code 0940 or 0949 with 36511-36513, 36515-36516 or 36522 CPT/HCPCS codes when billing for therapeutic aphaeresis claims.
• List each drug for each visit as a separate line item and include the service date.
• Use HCPCS codes, as required, for all pharmaceuticals when:
  o Billed with revenue codes 0250-0252, 0256-0259, or 063X. Include the units with pharmaceutical CPT/HCPCS codes
  o Billed with revenue codes 026X, 028X, 0331, 0335, 0940
• When using an unlisted CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CMS-1450 claim form.

Billing Institutional Claims
Ancillary Billing Overview
 UniCare follows ancillary billing guidelines as outlined in the state of West Virginia’s provider manual, located at the BMS website at www.dhhr.wv.gov/bms > Providers > Provider Manual.

Most ancillary claims are submitted for laboratory/diagnostic imaging or DME. The following sections provide the special billing requirements for each.

Please note: Because the member’s benefits may not cover some of the services listed, confirm benefit coverage first.

Billing Institutional Claims
Ambulance Services
Ambulance providers, including municipalities, should use the CMS-1500 claim form to bill for ambulance services. Use the appropriate two-digit origin and destination codes that describe the “to” and “from” locations.

Note: Only emergency ambulance services should be billed to UniCare. All nonemergency transportation services are covered through the Fee-for-Service Medicaid program.

Billing Institutional Claims
Ambulatory Surgical Centers
Most outpatient surgery delivered in an ambulatory surgery center requires prior authorization. Ambulatory surgical centers bill on the CMS-1450 claim form.

Billing Institutional Claims
Physical Therapy
The physical therapy setting determines the correct billing form:
• CMS-1500 claim form: When providing services in an office, clinic or outpatient setting
• CMS-1450 claim form: When providing services in a rehabilitation center or for physical therapists affiliated with home health agencies, providing services in a patient’s home

Billing Institutional Claims

Speech Therapy
The speech therapy setting determines the correct billing form:
• CMS-1500 claim form: When providing services in an office, clinic or outpatient setting
• CMS-1450 claim form: For speech therapists affiliated with home health agencies, providing services in a patient’s home

Please note:

Billing Institutional Claims

Occupational Therapy
The occupational therapy setting determines the correct billing form:
• CMS-1500 claim form: When providing services in an office, clinic or outpatient setting
• CMS-1450 claim form: For occupational therapists affiliated with home health agencies, providing services in a patient’s home

Billing Institutional Claims

Durable Medical Equipment
Billing for custom-made DME, prescribed to preserve bodily functions or prevent disability, requires prior authorization. Without such review, claims for DME will be denied. Prior to dispensing, contact UniCare’s UM department.

Please note: The presence of an HCPCS code does not necessarily mean that the benefit is covered or that payment will be made. Some DME codes may be By Report (customized) and therefore require additional information for pre- or post-service review and processing.

DME billing requires a differentiation between rentals and purchased equipment, as well as specific codes and modifiers. Special guidelines for DME billing:
• Use the appropriate modifier to identify rentals versus purchases (new or used). Claims submitted without the right modifier will be reimbursed at the rental rate.
• Use HCPCS codes for DME or supplies.
• Use an unlisted or miscellaneous code, such as E1399, when an HCPCS code does not exist for a particular item of equipment.
• Use valid codes for DME and supplies. If valid HCPCS codes exist, unlisted codes will not be accepted.
• Attach the manufacturer’s invoice to the claim if using a miscellaneous or unlisted code. The invoice must be from the manufacturer, not from the office making the purchase.

Please note: Catalogue pages are not acceptable as a manufacturer’s invoice.
Billing Institutional Claims

Durable Medical Equipment: Rentals
Most DME is dispensed on a rental basis and requires medical documentation from the prescribing provider. Rented items remain the property of the DME provider until the purchase price is reached. Charges for rentals exceeding the reasonable charge for a purchase are not accepted. Rental extensions may be obtained only on approved items.

Please note: DME providers should use normal equipment collection guidelines. UniCare is not responsible for equipment not returned by members.

Billing Institutional Claims

Durable Medical Equipment: Purchase
DME may be reimbursed on a rent-to-own basis over a period of 10 months, unless otherwise specified at the time of review by UniCare’s UM department.

Billing Institutional Claims

Durable Medical Equipment: Wheelchairs and Wheeled Mobility Aids
At UniCare, we follow Medicaid guidelines for calculating By Report (customized) wheelchair claims. Claims must include the following:

- Catalogue number
- Item description
- Manufacturer’s name
- Model number

Mark each catalogue page or invoice line so we can match each item to the appropriate claim line. Enter the total manufacturer’s suggested retail price (MSRP) of the wheelchair in the Reserved for Local Use field (Box 19) on the CMS-1500 claim form. The total MSRP includes:

- Accessories
- Modifications or replacement parts

Also provide the name of the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified technician.

For wheeled mobility aids, we have an additional requirement: The invoice must include a price published by the manufacturer before August 1, 2003. If the item was not available before this date, list the date of availability in the Reserved for Local Use field (Box 19) of the CMS-1500 claim form. Attach to the claim the catalogue page where the item was first published.

If you are a wheelchair manufacturer billing as a provider, your billing must include all of the above as well as the MSRP from a catalogue page dated before August 1, 2003. If the item was not available before that date, the manufacturer’s invoice must accompany the claim.
Billing Institutional Claims

Dialysis

Dialysis centers and other entities performing dialysis should use the CMS-1450 claim form to bill for dialysis services.

Note: The fee has been removed from CPT code 90999 (unlisted dialysis procedure, inpatient or outpatient). Any future billing of this code requires documentation of the actual services rendered.

Billing Institutional Claims

Home Infusion Therapy

Certain home infusion therapy codes require prior authorization. When billing for home infusion therapy, use the CMS-1500 claim form and follow these guidelines:

• Obtain prior authorization, as required, from UniCare’s UM department for all infusion therapy.
• Submit all claims within the contracted filing limit.
• Use the appropriate HCPCS codes to bill for all injections.
• Use HCPCS code J3490 along with the NDC for billing injections only if an appropriate injection code does not exist.

Billing Institutional Claims

Laboratory and Diagnostic Imaging

For laboratory and diagnostic imaging, use the CMS-1500 claim form and refer to the basic billing guidelines found in the Overview section of this chapter.

Billing Institutional Claims

Home Health Care

All home health care requires prior authorization. Contact UniCare’s UM department for prior authorization before delivery of service. When billing for a home health care visit, use the CMS-1450 claim form and bill using the appropriate revenue and HCPCS codes.

Please note: When billing for supplies and equipment used in a home health care visit, refer to the Durable Medical Equipment section in this chapter for billing requirements.

Billing Institutional Claims

Hospice

Hospice services require prior authorization. Contact UniCare’s UM department for prior authorization before hospice admission. When billing for hospice services, use the CMS-1450 claim form.

Billing Institutional Claims

Additional Billing Resources

The following reference books provide detailed instructions on uniform billing requirements:

• Current Procedural Terminology, published by the American Medical Association (AMA)
• Healthcare Common Procedure Coding System, National Level II (current year)
• International Classification of Diseases (current edition) Volumes 1,2,3 (current year), published by the Practice Management Information Corporation
Billing Institutional Claims

CMS-1450 Claim Form
All Medicare-approved facilities should bill UniCare using the most up-to-date version of the CMS-1450 claim form. All fields must be completed using standardized code sets. These code sets are used to ensure that claims are processed in an orderly and consistent manner. HCPCS provides codes for a variety of services and consists of Level I and Level II:

- Level I: CPT codes determined by the AMA and represented by five digits.
- Level II: Other codes identifying products, supplies and services not included in the CPT codes, such as ambulance services and DME. Sometimes referred to as the alphanumeric codes because they consist of a single alphabetical letter followed by four digits.

In some cases, two-digit/character modifier codes should accompany the level I or level II coding.

Billing Institutional Claims
CMS-1450 Revenue Codes
CMS-1450 revenue codes are required for all institutional claims.

Billing Institutional Claims
Institutional Inpatient Coding
For institutional inpatient coding, use the guidelines in the following code manuals:

- Use current ICD applicable and procedure codes in Boxes 74-74e of the CMS-1450 claim form when the claim indicates that a procedure was performed.
- Use modifier codes when appropriate; refer to the current edition of the provider’s CPT manual published by the AMA.
- Refer to your provider’s contract for DRG information.

Billing Institutional Claims
Institutional Outpatient Coding
For institutional outpatient coding, use the guidelines in the following code manuals:


Please note: When using an unlisted CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CMS-1450 claim form.

Billing Institutional Claims
Recommended Fields for the CMS-1450 Claim Form
The following guidelines will assist in completing the CMS-1450 claim form. An “R” indicates a mandatory field.

<table>
<thead>
<tr>
<th>Field #</th>
<th>Box Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (R)</td>
<td>Blank</td>
<td>Field intentionally left blank. Facility name, address and phone number.</td>
</tr>
<tr>
<td>Field #</td>
<td>Box Title</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>2</td>
<td>Blank</td>
<td>Field intentionally left blank. Required when the address for payment is different than that of the Billing Provider information located in Field 1.</td>
</tr>
<tr>
<td>3a</td>
<td>PAT. CNTL #</td>
<td>Member’s account number.</td>
</tr>
<tr>
<td>3b</td>
<td>MED. REC #</td>
<td>Member’s record number, which can be up to 20 characters long.</td>
</tr>
<tr>
<td>4 (R)</td>
<td>TYPE OF BILL</td>
<td>Enter the Type of Bill (TOB) code.</td>
</tr>
<tr>
<td>5 (R)</td>
<td>FED. TAX NO.</td>
<td>Enter the Provider’s federal tax identification number.</td>
</tr>
<tr>
<td>6 (R)</td>
<td>STATEMENT COVERS PERIOD</td>
<td>“FROM” and “THROUGH” date(s) covered by the claim being submitted.</td>
</tr>
<tr>
<td>8a–b (R)</td>
<td>PATIENT NAME</td>
<td>Member’s name.</td>
</tr>
<tr>
<td>9a–e (R)</td>
<td>PATIENT ADDRESS</td>
<td>Member’s complete address (number, street, city, state, ZIP code and telephone number).</td>
</tr>
<tr>
<td>10 (R)</td>
<td>BIRTHDATE</td>
<td>Member’s date of birth in MM/DD/YY format.</td>
</tr>
<tr>
<td>11 (R)</td>
<td>SEX</td>
<td>Member’s gender.</td>
</tr>
<tr>
<td>12 (R)</td>
<td>ADMISSION DATE</td>
<td>Member’s admission date to the facility in MM/DD/YY format.</td>
</tr>
<tr>
<td>13 (R)</td>
<td>ADMISSION HR</td>
<td>Member’s admission hour to the facility in military time (00 to 23) format.</td>
</tr>
<tr>
<td>14 (R)</td>
<td>ADMISSION TYPE</td>
<td>Type of admission.</td>
</tr>
<tr>
<td>15 (R)</td>
<td>ADMISSION SRC</td>
<td>Source of admission.</td>
</tr>
<tr>
<td>16 (R)</td>
<td>DHR</td>
<td>Member’s discharge hour from the facility in military time (00 to 23) format.</td>
</tr>
<tr>
<td>17 (R)</td>
<td>STAT</td>
<td>Patient status.</td>
</tr>
<tr>
<td>18–28</td>
<td>CONDITION CODES</td>
<td>Enter Condition Code (81) X0 – X9.</td>
</tr>
<tr>
<td>29</td>
<td>ACDT STATE</td>
<td>Accident state.</td>
</tr>
<tr>
<td>31–34 (R)</td>
<td>OCCURRENCE CODE OCCURRENCE DATE</td>
<td>Occurrence code (42) and date, if applicable.</td>
</tr>
<tr>
<td>35–36</td>
<td>OCCURRENCE SPAN (CODE, FROM and THROUGH)</td>
<td>Enter dates in MM/DD/YY format.</td>
</tr>
<tr>
<td>38</td>
<td>Blank</td>
<td>Field intentionally left blank. Enter the responsible party name and address, if applicable.</td>
</tr>
<tr>
<td>39–41</td>
<td>VALUE CODES (CODE and AMOUNT)</td>
<td>Enter value codes, if applicable.</td>
</tr>
<tr>
<td>42 (R)</td>
<td>REV. CD.</td>
<td>Revenue Code, required for all institutional claims.</td>
</tr>
<tr>
<td>43 (R)</td>
<td>DESCRIPTION</td>
<td>Description of services rendered.</td>
</tr>
<tr>
<td>44 (R)</td>
<td>HCPCS/RATE/HIPPS CODE</td>
<td>Enter the accommodation rate per day for inpatient services or HCPCS/CPT code for outpatient services.</td>
</tr>
<tr>
<td>45 (R)</td>
<td>SERV. DATE</td>
<td>Date of services rendered.</td>
</tr>
<tr>
<td>46 (R)</td>
<td>SERV. UNITS</td>
<td>Number/units of occurrence for each line or service being billed.</td>
</tr>
<tr>
<td>47 (R)</td>
<td>TOTAL CHARGES</td>
<td>Total charge for each line of service being billed.</td>
</tr>
<tr>
<td>48</td>
<td>NON-COVERED CHARGES</td>
<td>Enter any non-covered charges.</td>
</tr>
<tr>
<td>50</td>
<td>PAYER NAME</td>
<td>Payer Identification. Enter any third-party payers.</td>
</tr>
<tr>
<td>51 (R)</td>
<td>HEALTH PLAN ID</td>
<td>Leave blank. Assigned by UniCare.</td>
</tr>
<tr>
<td>52 (R)</td>
<td>REL. INFO</td>
<td>Release of information certification indicator.</td>
</tr>
<tr>
<td>53</td>
<td>ASG BEN.</td>
<td>Assignment of benefits certification indicator.</td>
</tr>
<tr>
<td>54</td>
<td>PRIOR PAYMENTS</td>
<td>Prior payments.</td>
</tr>
<tr>
<td>55</td>
<td>EST. AMOUNT DUE</td>
<td>Estimated amount due.</td>
</tr>
<tr>
<td>Field #</td>
<td>Box Title</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>56 (R)</td>
<td>NPI</td>
<td>Enter the Provider’s National Provider Identifier (NPI) number.</td>
</tr>
<tr>
<td>57 (R)</td>
<td>OTHER PRIV ID</td>
<td>Enter the NPI of the other Provider, if any.</td>
</tr>
<tr>
<td>58 (R)</td>
<td>INSURED’S NAME</td>
<td>Member’s name.</td>
</tr>
<tr>
<td>59 (R)</td>
<td>P. REL</td>
<td>Patient’s relationship to insured. Enter N/A if Member is the insured.</td>
</tr>
<tr>
<td>60 (R)</td>
<td>INSURED’S UNIQUE ID</td>
<td>Use the Medicaid Identification (ID) number.</td>
</tr>
<tr>
<td>61</td>
<td>GROUP NAME</td>
<td>Insured group name. Enter the name of any other health plan.</td>
</tr>
<tr>
<td>62</td>
<td>INSURANCE GROUP NO.</td>
<td>Enter the policy number of any other health plan.</td>
</tr>
<tr>
<td>63</td>
<td>TREATMENT AUTHORIZATION CODES</td>
<td>Authorization number or authorization information must be entered on this field.</td>
</tr>
<tr>
<td>64</td>
<td>DOCUMENT CONTROL NUMBER</td>
<td>The control number assigned to the original bill.</td>
</tr>
<tr>
<td>65</td>
<td>EMPLOYER NAME</td>
<td>Name of organization from which the insured obtained the other policy.</td>
</tr>
<tr>
<td>66 (R)</td>
<td>DX/PROC qualifier</td>
<td>Enter the diagnosis and procedure code qualifier (ICD version indicator).</td>
</tr>
<tr>
<td>67 (R)</td>
<td>DX</td>
<td>Principal Diagnosis Codes. Enter the ICD diagnostic codes, if applicable.</td>
</tr>
<tr>
<td>67a–q (R)</td>
<td>DX</td>
<td>Other Diagnostic Codes. Enter the ICD diagnostic codes, if applicable.</td>
</tr>
<tr>
<td>69</td>
<td>ADMIT DX</td>
<td>Admission diagnosis code. Enter the ICD code.</td>
</tr>
<tr>
<td>70a–c</td>
<td>PATIENT REASON DX</td>
<td>Enter the Member’s reason for this visit, if applicable.</td>
</tr>
<tr>
<td>71</td>
<td>PPS CODE</td>
<td>Prospective Payment System (PPS) code (not required).</td>
</tr>
<tr>
<td>72</td>
<td>ECI</td>
<td>External cause of injury code.</td>
</tr>
<tr>
<td>74 (R)</td>
<td>PRINCIPAL PROCEDURE (CODE/DATE)</td>
<td>ICD principal procedure code and dates, if applicable.</td>
</tr>
<tr>
<td>74a–e (R)</td>
<td>OTHER PROCEDURE (CODE/DATE)</td>
<td>Other Procedure Codes.</td>
</tr>
<tr>
<td>76 (R)</td>
<td>ATTENDING</td>
<td>Enter the attending Provider’s ID number. The NPI is required.</td>
</tr>
<tr>
<td>77 (R)</td>
<td>OPERATING</td>
<td>Enter the Provider number if you use a surgical procedure on this form. The NPI is required.</td>
</tr>
<tr>
<td>78–79</td>
<td>OTHER</td>
<td>Enter additional Provider numbers, if applicable. The NPI is required.</td>
</tr>
<tr>
<td>80</td>
<td>REMARKS</td>
<td>Use this field to explain special situations.</td>
</tr>
<tr>
<td>81a–d (R)</td>
<td>CC</td>
<td>Enter the taxonomy code with qualifier B3.</td>
</tr>
</tbody>
</table>
CHAPTER 11: MEMBER TRANSFERS AND DISENROLLMENT

Customer Care Center phone: 1-800-782-0095
Customer Care Center fax: 1-888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Member Transfers and Disenrollment

Member PCP Reassignments
When members enroll in any of our programs, they choose a PCP or allow their PCP to be assigned. However, members may change their PCP at any time. If a member wants to make a change after enrollment, the member is instructed to call our Customer Care Center to request an alternate PCP or the member may make PCP changes and request new ID cards from the member website.

UniCare accommodates members’ requests for reassignment whenever possible. Our staff works with the member to make the new selection and focuses on any special needs. Our policy is to maintain continued access to care and continuity of care during the reassignment process.

The effective date of a reassignment typically is the same as the date other member requests the change, but may be assigned retroactively or upon discharge if the member is hospitalized. To support member reassignments, PCPs are encouraged to maintain open panels. The state requires that 80% of UniCare’s PCPs have open panels. Your open panel will assist us in meeting this requirement.

Open panel: The commitment by a UniCare provider to accept new UniCare members.

Member Transfers and Disenrollment

PCP Initiated Member Reassignments
A PCP may request reassignment of a member from his or her primary care assignment. The PCP may request a member be reassigned if the member:

- Is abusive to the PCP, exhibiting disruptive, unruly, threatening or uncooperative behavior
- Is abusive to staff, exhibiting disruptive, unruly, threatening or uncooperative behavior
- Misuses or loans their membership card to another person
- Fails to follow prescribed treatment plans

To request member reassignment to a different PCP, perform the following:

- Complete the UniCare Provider Request for Member Deletion from Primary Care Physician (PCP) Assignment form, located in the Forms and Tools section of the Provider Resources page of our website at www.unicare.com. Click on UniCare Provider Request for Member Deletion from Primary Care Physician (PCP) Assignment. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

- Mail or fax (preferred) the form to UniCare:
  UniCare Health Plan of West Virginia, Inc.
  P.O. Box 91
  Charleston, WV 25321-0091
  Fax: 1-888-438-5209
Member Transfers and Disenrollment

State Agency-Initiated Member Disenrollment
Contracted state agencies inform UniCare of membership changes by sending monthly enrollment reports. These reports contain all active membership data and incremental changes to eligibility records. UniCare disenrolls members not listed on the monthly report. Reasons for disenrollment may include:

• Admission to a long-term care or intermediate care facility beyond the month of admission and the following month
• Change in eligibility status
• County changes
• Death
• Loss of benefits
• Member has other nongovernment or government sponsored health coverage
• Permanent change of residence out of the service area
• Voluntary disenrollment

Member Transfers and Disenrollment
PCP-Initiated Member Disenrollment
A PCP may request disenrollment of a member from his or her primary care assignment. The PCP may request member disenrollment if the member:

• Is abusive to the PCP, exhibiting disruptive, unruly, threatening or uncooperative behavior
• Is abusive to staff, exhibiting disruptive, unruly, threatening or uncooperative behavior
• Misuses or loans their membership card to another person
• Fails to follow prescribed treatment plans

To request disenrollment, the PCP must perform the following:

• Complete the UniCare Provider Request for Member Deletion from Primary Care Physician (PCP) Assignment form, located in the Forms and Tools section of the Provider Resources page of our website: www.unicare.com. Click on UniCare Provider Request for Member Deletion from Primary Care Physician (PCP) Assignment. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.
• Mail form in:
  UniCare Health Plan of West Virginia, Inc.
  P.O. Box 91
  Charleston, WV 25321-0091
  Call customer service
  Member can change PCP by accessing the member online portal

The provider is expected to coordinate service for up to 30 days after the date UniCare receives the change request form. Upon completing the PCP assignment change, UniCare forwards the form and any other information related to the case to the quality assurance facilitator. The facilitator informs the member of the change within five working days. The change will be effective on the day UniCare enters the change into the system.

UniCare notifies PCPs of member reassignments through monthly enrollment reports. PCPs may find these reports on our secure provider website at www.unicare.com. Providers may also call our
Customer Care Center at **1-800-782-0095**. The effective date of a PCP reassignment will be the same date of the member request.

**Member Transfers and Disenrollment**

**Member Initiated Disenrollment**

UniCare enrollees may request disenrollment at any time for any reason. Disenrollment shall be effective no later than the first day of the second month in which the enrollee requests disenrollment. Members should contact the enrollment broker to initiate disenrollment. If an enrollee informs UniCare of a request to transfer to another MCO, UniCare will work with the enrollment broker to facilitate the process.

**Member Transfers and Disenrollment**

**Involuntary Member Disenrollment**

Involuntary beneficiary disenrollment from UniCare may occur for the following reasons:

- Loss of eligibility for Medicaid or for participation in Medicaid Managed Care
- Failure of BMS to make a premium payment on behalf of the member
- The beneficiary’s permanent residence changes to a location outside of UniCare’s Medicaid service area. However, if the resident moves to a location serviced by other MCOs, the resident must reenroll into a new MCO as soon as administratively possible
- Continuous placement in a nursing facility, state institution or intermediate care facility for the mentally retarded for more than 30 calendar days
- Error in enrollment. This may occur if the beneficiary was inaccurately classified as eligible for enrollment with UniCare. If the beneficiary does not meet eligibility requirements for eligibility groups permitted to enroll with UniCare, or after a request for exemption is approved, if the enrollment broker enrolled the beneficiary while their exemption request was being considered.
- Beneficiary death
- Member is at any stage of the transplant process

When members enroll in our program, we provide instructions on disenrollment procedures. Disenrollment becomes effective on the last day of the calendar month following administrative cut-off or is subject to state cut-off.

If a member asks a provider how to disenroll from UniCare, the provider should direct the member to call the Customer Care Center at **1-800-782-0095**. The member will be transferred from the Customer Care Center to the state’s enrollment broker phone number. The state’s enrollment broker determines membership eligibility and performs enrollment and disenrollment procedures.

**Please note:** Providers may not take retaliatory action against any member for requesting reassignment.
CHAPTER 12: GRIEVANCES AND APPEALS

Customer Care Center and
Grievance and Appeals phone:  1-800-782-0095
Customer Care Center fax:  1-888-438-5209
Grievance and Appeals fax:  1-866-387-2968
Hours of operation:   Monday to Friday, 8 a.m. to 6 p.m.

Grievances and Appeals
Overview
We encourage UniCare providers and members to seek resolution of issues through our grievances and appeals process. The issues may involve dissatisfaction or concern about another provider, the plan or a member.

We want to assure providers that they have the right to file an appeal with us for denial, deferral or modification of a claims disposition or post-service request. Providers also have the right to appeal on behalf of a member for denial, deferral or modification of a prior authorization or request for concurrent review. These appeals are treated as member appeals and follow the member appeal process.

Grievances are tracked and trended, resolved within established time frames, and referred to a peer review when needed. The UniCare grievances and appeals process meets all requirements of state and federal law and accreditation agencies.

The building blocks of this process are the adverse benefit determination, grievance, grievance appeal and appeal.

An adverse benefit determination is any of the following:
• A denial or limited authorization of a requested service, including determinations based on the type, level of service, medical necessity, appropriateness, setting or effectiveness of a covered benefit
• A reduction, suspension or termination of a previously authorized service
• A denial, in whole or in part, of a payment for a service
• Failure to provide services in a timely manner
• Failure to adhere to the required time frames for standard resolution of grievances and appeals
• For a resident of a rural area with only one MCO, the denial of the member’s request to obtain services outside the network
• The denial of the member’s request to dispute financial liability

A complaint is the same as a grievance. It’s an expression of dissatisfaction made about UniCare’s decision or services received from UniCare when an informal grievance is filed; some complaints may be subject to appeal. If a distinction cannot be made between a grievance and an inquiry, it is considered a grievance.

A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination, either in writing (formally) or orally (informal), to UniCare by a provider or member about any aspect of our or the provider’s operation, the provision of health care services, or the activities or behaviors (other than our action) as defined in this chapter.

A grievance appeal is a formal request for UniCare to review a grievance resolution.
An **appeal** is a review by UniCare of an adverse benefit determination.

An **expedited appeal** is an appeal when UniCare determines, or the provider indicates in making the request on the member’s behalf or supporting the member’s request, that taking the time for a standard appeal could seriously jeopardize the member’s life or health or ability to attain, maintain or regain maximum function.

An **inquiry** is a request for additional information or clarification regarding benefit coverage or how to access medical care/covered benefits. An inquiry is an informational request that is handled at the point of entry or that is forwarded to the appropriate operational area for final response. An inquiry is not an expression of any dissatisfaction.

An **action** is a:

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension or termination of a previously authorized service.
- Denial, in whole or in part, of a payment for a service.
- Failure to provide services in a timely manner, as defined by the state.
- Failure to act within the time frames specified by the state.

If a provider or member has a grievance, UniCare would like to hear about the issue either by phone or in writing. Providers and members have the right to file a grievance regarding any aspect of UniCare’s services.

**Please note:** UniCare does not discriminate against members or providers for filing a grievance or an appeal. Providers are prohibited from penalizing a member in any way for filing a grievance.

Provider grievances and appeals are classified into the following categories:

- Provider grievances relating to the operation of the plan, including:
  - Benefit interpretation
  - Claim processing
  - Reimbursement
- Provider appeals related to actions

Member grievances, grievance appeals and appeals include, but are not limited to, the following:

- Access to health care services
- Care and treatment by a provider
- Issues having to do with how we conduct business

**Please note:** UniCare offers members an expedited appeals process for decisions involving urgently needed care. Both standard and expedited appeals are reviewed by a person who is not subordinate to the initial decision-maker.

**Grievances and Appeals**

**Providers: Grievances Relating to the Operation of the Plan**

A provider may be dissatisfied or concerned about another provider, a member, or an operational issue, including claims processing and reimbursement. To file a grievance, download the Provider Grievance Form available in the Forms and Tools section of the Provider Resources page of our website:
www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Provider grievances may be submitted in writing and must include the following:
- Provider’s name
- Date of the incident
- Description of the incident

Mail the form to the following address:
UniCare Health Plan of West Virginia, Inc.
Attn: Grievance and Appeals Department
P.O. Box 91
Charleston, WV 25321-0091

Or fax the form to 1-866-387-2968.

A grievance may be filed any time a provider becomes aware of the problem. UniCare will send a written acknowledgement to the provider within five calendar days of receiving a grievance. UniCare may request medical records or an explanation of the issues raised in the grievance by:
- Phone.
- Fax, with a signed and dated letter.
- Mail, with a signed and dated letter.

The timeline for responding to the request for more information is as follows: For standard grievances or appeals, providers must comply with the request for additional information within 10 calendar days of the date that appears on the request.

Grievances and Appeals
Providers: Grievance Response Timeline
UniCare notifies providers in writing of the resolution, including their right of appeal, if any. Findings or decisions of peer review or quality of care issues are not disclosed. UniCare sends a written resolution letter to the provider upon receipt of the grievance.
- Provider grievances: UniCare sends a written resolution letter to the provider within 30 calendar days of the receipt of the grievance.
- Provider medical necessity appeals: UniCare sends a written resolution letter to the provider within 30 calendar days of the receipt of the appeal.

Grievances and Appeals
Providers: Claims Disputes and Payment Appeals
If a provider does not agree with the outcome of a claim determination, the provider may challenge the decision by using the claim payment appeals process. If there is a full or partial claim rejection or the payment is not the amount expected, submit a claims appeal.

The appeal must be received by UniCare within 365 days from the date on the notice of the letter advising of the action. Multiple claims for the same situation may be submitted with the same appeal.

Mail the appeal to:
UniCare Health Plan of West Virginia, Inc.
Attn: Grievance and Appeals Department  
P.O. Box 91  
Charleston, WV 25321-0091

Request for provider disputes must be submitted using the following guideline: The request must be made in writing to UniCare within 365 calendar days of a claims disposition and include all pertinent information. Provider dispute resolution appeals are resolved within 45 business days of receipt of the written request.

Grievances and Appeals  
**Providers: Claim Payment Appeals Resolutions**  
Claim payment appeals are resolved within 30 days of receipt of the written request. When we resolve a claim payment appeal regarding a previous claim disposition, a resolution letter with the details of our decision is sent to the provider.

Grievances and Appeals  
**Members: Grievances and Appeals**  
To help ensure that members’ rights are protected, all UniCare members are entitled to a grievance, grievance appeal and appeals process. The building blocks of this process are the grievance, the grievance appeal and the appeal:

**Grievance:** An expression of dissatisfaction, either in writing (formal) or orally (informal) to UniCare by a provider or member about any aspect of our or the provider’s operation, the provision of health care services, or the activities or behaviors (other than our action) as defined in this chapter. If a distinction cannot be made between a grievance and an inquiry, it is considered a grievance.

**Grievance appeal:** A formal request for UniCare to review a grievance resolution.

**Appeal:** A formal request for UniCare to review an action.

Members have the following time periods to file:

- **Grievance:** any time the member becomes aware of the problem
- **Grievance appeal:** within 60 calendar days of the date when the grievance was resolved
- **Appeal:** within 60 calendar days of the date on the adverse benefit determination letter

**Members: Grievances**

If a member wants to file a grievance, the member may call the Customer Care Center, write a letter to the Grievance and Appeals department telling us about the problem or fill out a grievance form available on our website. Grievance forms are available wherever members receive their health care, such as at their PCP’s office or at a local UniCare resources office. The member will need to tell us the following:

- Who is part of the grievance
- What happened
- When the incident happened
- Where the incident happened
• Why they were not happy with the health care services received

Attach documents that will help us look into the problem. Mail the grievance form to:

UniCare Health Plan of West Virginia, Inc.
Attn: Grievance and Appeals Department
P.O. Box 91
Charleston, WV 25321-0091

The member does not have to be the person filing a grievance or appeal. Other representatives may include the following:

• Relative
• Guardian
• Conservator
• Attorney
• Member’s PCP or a provider on behalf of the member

Members will be required to sign an authorized representative form. If the member is a minor or is incompetent or incapacitated, the member’s representative may submit the grievance or appeal on the member’s behalf.

If the member cannot mail the form or letter, he or she may call UniCare’s Customer Care Center, and we will provide assistance by documenting the request. We send the member an acknowledgment letter within five calendar days after receiving the grievance by mail or phone. The acknowledgement letter includes the receipt date as well as the name and contact information of a representative who may be contacted. UniCare sends a grievance resolution letter to the member within 30 calendar days after receiving the grievance.

Please note: A member’s grievance related to an action already taken is considered an appeal.

Grievances and Appeals

Members: Grievance Appeals

If a member is not satisfied by the response to a grievance, the member may file a grievance appeal within 60 days. The Member Grievance Form, which members may request by calling the Customer Care Center at 1-800-782-0095, may be filed by fax or mailed to the following address:

UniCare Health Plan of West Virginia, Inc.
ATTN: Grievance and Appeals Department
P.O. Box 91
Charleston, WV 25321-0091
Grievance and Appeal fax: 1-866-387-2968

After we receive the member’s grievance form by fax or mail, we will send an acknowledgment letter within ten calendar days from the date we receive it.
Grievances and Appeals

Members: Grievances Appeal Resolutions
UniCare will investigate the member’s grievance appeal to develop a resolution. This investigation includes the following steps:

• UniCare will have the grievance reviewed by appropriate staff and, if necessary, the medical director.
• UniCare may request medical records or an explanation from the provider(s) involved in the case.
• UniCare will notify providers of the need for additional information either by phone, mail or fax. Written correspondence to providers will include a signed and dated letter.
• Providers are expected to comply with requests for additional information within 10 calendar days.
• Within 15 calendar days, UniCare will arrange a grievance appeal panel meeting where the member can communicate their concerns directly to the panel. Members may attend either in person or through appropriate means if the member cannot attend in person.

The member will receive a grievance appeal resolution letter within 45 business days of the date we receive the grievance appeal request. The letter will:

• Describe their grievance appeal.
• Tell them what will be done to solve the problem.
• Tell them how to contact the West Virginia Department of Health and Human Resources (DHHR).

Grievances and Appeals

Members: Filing Appeals
Members have the right to appeal UniCare’s denial of services or payment for services, in whole or in part. A denial of this type is called an action. With the exception of expedited appeals, all verbal appeals must be confirmed in writing and signed by the member or his or her representative. A member’s grievance related to an action is considered an appeal.

Appeals filed by the authorized representative, provider or provider on behalf of the member require written consent from a member. UniCare will send an acknowledgement letter to the member that includes an authorized representative form and a request for the member to submit their written consent.

Action: The denial or limited authorization of a requested service, including the type or level of service

Actions may include the following:

• Denial or limited authorization of a requested service, including the type or level of service
• Reduction, suspension or termination of a previously authorized service
• Denial, in whole or in part, of payment for service
• Failure to provide services in a timely manner, as defined by the state of West Virginia
• Failure of UniCare to act within required timeframes
• For a resident of a rural area with only 1 contractor, the denial of a member’s request to exercise his/her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside of the network, if applicable

Please note: UniCare will resolve any grievance or appeal, internal or external, at no cost to the member.
Member appeals are divided into the following categories:

**Standard Appeal:** The appropriate process when a member or his/her representative requests that UniCare reconsider the denial of a service or payment for services, in whole or in part.

**Expedited Appeal:** An appeal when UniCare determines, or the provider indicates when making the request on the member’s behalf or supporting the member’s request, that taking the time for a standard appeal could seriously jeopardize the member’s life or health or ability to attain, maintain or regain maximum function.

**Grievances and Appeals**

**Members: Response to Standard Appeals**
After a written appeal request is received, the case is taken under consideration and investigated by UniCare’s Grievances and Appeals department. The member, his or her representative, and the provider are given the opportunity to submit written comments and documentation relevant to the appeal. UniCare may request medical records or a provider explanation of the issues raised in the appeal by:
- Phone.
- Fax, with a signed and dated letter.
- Mail, with a signed and dated letter.

Providers are expected to comply with the request for additional information within 10 calendar days. When the appeal is the result of a medical necessity determination, a health care professional who was not involved in the initial decision reviews the case. The health care professional contacts the provider, if needed, to discuss possible alternatives.

Upon request of an appeal, members and their authorized representative are provided with a copy of their case file.

**Grievances and Appeals**

**Members: Resolution of Standard Appeals**
Standard appeals are resolved within 30 calendar days of receipt of the initial written or verbal request. Members are notified in writing of the appeal resolution, including their right to further appeal, if any. The decision will be final and the provider will have no further right of appeal related to the action in question.

**Grievances and Appeals**

**Members: Extensions**
If UniCare is unable to resolve the appeal within the standard 30 days or 72 hours, the resolution time frame for an appeal not related to an ongoing hospitalization or emergency may be extended up to 14 calendar days if:
- The member or representative requests an extension
- UniCare demonstrates there is a need for additional information and the delay is in the member’s interest. UniCare must submit documentation to the West Virginia Bureau for Medical Services (BMS) that the extension is in the member’s best interest. If BMS approves the extension, we immediately provide the member with written notice of the reason for the extension and the date the decision will be made. UniCare will attempt to contact the member by phone to notify him or
her of the extension on the resolution of the initial request. This notice will be provided within two
calendar days and will include notification of the member’s right to file a grievance if he or she
disagrees with the extension. We maintain documentation of any extension request.

Grievances and Appeals
**Members: Expedited Appeals**
If the amount of time necessary to participate in a standard appeal process could jeopardize the
member’s life, health, or ability to attain, maintain or regain maximum function, the member may
request an expedited appeal. UniCare will inform the member of the time available for providing
information and that limited time is available for expedited appeals. Members may request an
expedited appeal by calling our Customer Care Center at 1-800-782-0095.

UniCare may also extend the time frame for expedited appeals resolution by 14 calendar days and will
make reasonable efforts to provide oral notice to the member of the resolution. UniCare will attempt to
contact the member by phone to notify him or her of the extension on the resolution of the initial
request. This notice will be provided within two calendar days and will include notification of the
member’s right to file a grievance if he or she disagrees with the extension.

Grievances and Appeals
**Members: Timeline for Expedited Appeals**
Members have the right to request an expedited appeal within 30 calendar days from the date on the
initial notice of action letter. Expedited appeals are acknowledged by telephone, if possible, and are
resolved within 72 hours of the date we receive the request. A written resolution is sent within 72 hours
of the date we receive the expedited appeal.

If UniCare denies a request for an expedited appeal, we must:
- Transfer the appeal to the time frame for standard resolution.
- Make a reasonable effort to give the member prompt verbal notice of the denial and follow up
  within two calendar days with written notice.

Grievances and Appeals
**Members: Response to Expedited Appeals**
UniCare may request medical records or a provider explanation of the issues raised in an expedited
appeal by:
- Phone
- Fax, with a signed and dated letter
- Mail, with a signed and dated letter

Providers are expected to comply with the request for additional information within 24 hours.

Grievances and Appeals
**Members: Resolution of Expedited Appeals**
UniCare resolves expedited appeals as quickly as possible and within 72 hours. The member is notified
by telephone of the resolution, if possible. UniCare follows up with a written resolution letter within
72 hours of the expedited appeal decision.
Grievances and Appeals
Members: Other Options for Filing Grievances
If a member is dissatisfied with the appeal decision after exhausting UniCare’s grievances and appeals process, the member has the right to file an appeal with the Bureau for Medical Services (BMS) and request a state fair hearing within 120 calendar days from the date of the notice of action resolution letter. A provider does not have an appeal right with BMS.

Grievances and Appeals
Members: State Fair Hearing
UniCare members may request a state fair hearing after they have exhausted all of UniCare’s internal appeals processes. The request must be submitted in writing to the state of West Virginia within 120 calendar days from the date of the notice of action resolution letter:
- West Virginia Department of Health and Human Resources
  One Davis Square, Suite 100 East
  Charleston, WV 25301
  Phone: 1-304-558-0684
  Fax: 1-304-558-1130

The process is as follows:
- The state sends a notice of the hearing request to UniCare.
- Upon receipt of the request, all documents related to the request are forwarded to the state.
- The state notifies all parties of the date, time and place of the hearing. Representatives from UniCare’s administrative, medical and legal departments may attend the hearing to present testimony and arguments. UniCare’s representatives may cross-examine the witnesses and offer rebutting evidence.
- An administrative law judge renders a decision in the hearing within 90 days of the date the standard hearing request was made.
- If the judge overturns UniCare’s position, UniCare must adhere to the judge’s decision and ensure the decision is carried out.

Grievances and Appeals
Members: Confidentiality
All grievances and appeals are handled in a confidential manner. UniCare does not discriminate against a member for filing a grievance or requesting a state fair hearing. We notify members of the opportunity to receive information about our grievances and appeals process. Members may request a translated version in a language other than English.

Grievances and Appeals
Members: Discrimination
Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a UniCare representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident or is assisted in doing so, if he or she requests assistance.

We document, track and trend all alleged acts of discrimination. UniCare will review and trend cultural and linguistic grievances in collaboration with the Multicultural Health Strategy department.
Grievances and Appeals

Members: Continuation of Benefits during Appeal
UniCare members continue to receive benefits while their appeal is pending, in accordance with federal regulations, when all of the following criteria are met:

• The member or representative must request the appeal within 10 days of our mail date of the adverse action notification, or prior to the effective date on the written notice if the initial notification was made by phone.

• The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.

• Services were ordered by an authorized provider.

• The original period covered by the initial authorization has not expired.

• The member requests extension of benefits.
CHAPTER 13: CREDENTIALING AND REcredentialing

Customer Care Center phone: 1-800-782-0095
Customer Care Center fax: 1-888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Credentialing and Recredentialing

Overview
Credentialing is the process of validating the professional competency and conduct of network providers. The process involves verifying licensure, board certification, education and identification of adverse actions, including malpractice or negligence claims through the applicable state agencies and the National Practitioner Database.

We require recredentialing every three years to stay current with your professional information. Recredentialing is essential to our members as well, who depend on the accuracy of the information in the online UniCare Provider Finder®.

UniCare has streamlined the credentialing process by teaming up with the Council for Affordable Quality Healthcare (CAQH), nationally recognized for its thoroughness in collecting provider data.

Credentialing and Recredentialing

Council for Affordable Quality Healthcare
UniCare strongly encourages West Virginia providers to use CAQH’s ProView for initial credentialing and periodic recredentialing. CAQH is a not-for-profit alliance of the nation’s leading health care plans and networks whose mission is to improve health care quality and access for more than 165 million Americans covered by these plans. The CAQH data collection system from over 1.3 million providers allows administrative requirements to be streamlined.

ProView is the industry standard for collecting the provider data used in credentialing. Providers in all 50 states and the District of Columbia are able to enter information free of charge, reducing paperwork for more than 550 participating health care plans. ProView allows providers to fill out a single application to meet the credentialing data needs of multiple organizations. For both UniCare and providers, recredentialing is helpful because this process:

- Supports UniCare’s administrative streamlining and paper reduction efforts
- Helps to ensure the accuracy and integrity of the provider database
- Simplifies the credentialing application process, eliminating redundant application forms and streamlining paperwork for providers
- Enables providers to utilize the ProView database at no cost

Credentialing and Recredentialing

CAQH ProView Registration: First Time Users
UniCare providers must have CAQH provider identification number to register and begin the credentialing process. Perform the following steps if you are not registered with CAQH:

1. After you obtain a UniCare provider application packet and submit a current, signed UniCare agreement, UniCare will add your name to the CAQH roster.
2. Go to the CAQH website at https://proview.caqh.org/pr to obtain a CAQH ID number, complete your application and authorize UniCare. Providers who do not have Internet access should contact the CAQH Help Desk at 1-888-599-1771.

Please note: Registration and completion of the online application are free.

Credentialing and Recredentialing
CAQH/ProView Registration: Completing the Application Process
The ProView standardized application is a single, standard online form that meets the needs of all participating health care organizations. When completing the application, indicate which participating health care plans and health care organizations you authorize to access your application data. All data you submit through the ProView service is maintained by CAQH in its secure data center.

The following materials will be helpful while completing the ProView online application:
• Previously-completed credentialing application
• List of previous and current practice locations
• Various ID numbers (NPI, Medicare, Medicaid, etc.)
• State license(s) applicable to your provider type
• Current Drug Enforcement Administration (DEA) Certificate, if applicable
• Current Controlled and Dangerous Substances Certificate, if applicable
• Internal Revenue Service (IRS) Form W-9(s)
• Current malpractice insurance face sheet
• Summary of all pending or settled malpractice cases within the past 10 years
• Curriculum vitae

After completing the online credentialing application, you will be asked to:
• Authorize access to your information by selecting the checkbox next to UniCare. Or, select the global authorization option.
• Verify your data entry and attestation for accuracy and completeness.
• Upload supporting documents directly to the site. The following are required:
  o State license(s) applicable to your provider type
  o Current DEA Certificate, if applicable
  o Current Controlled and Dangerous Substances Certificate, if applicable
  o Current malpractice insurance face sheet
  o Summary of all pending or settled malpractice case(s) within the past 10 years
  o Curriculum vitae
  o Current signed attestation
  o Hospital Coverage Letter (required by UniCare from providers who do not have admitting privileges at a participating network hospital)

Please note: While the CAQH credentialing data set is substantially complete, UniCare may need to supplement, clarify or confirm certain responses on your application on a case-by-case basis. UniCare will reach out to the credentialing contact provided on the CAQH application to obtain additional information as necessary.
If you have any questions about accessing the ProView database, contact the CAQH Help Desk: 1-888-599-1771. To download a quick reference guide about completing the CAQH registration process, go to https://proview.caqh.org.

Credentialing and Recredentialing
CAQH/ProView Registration: Existing Users
If you have registered your CAQH Provider ID and completed your online application through participation with another health care plan, log on to the ProView database and authorize UniCare to access your information. Follow these steps:

1. Go to: https://proview.caqh.org/pr.
2. In the Sign In section, enter your username and password and select Sign In.
3. Select the Authorize tab located under the CAQH logo.
4. Scroll down to locate UniCare. Select the checkbox next to UniCare or select the global authorization option.
5. Select Save to submit your changes.

Visit the CAQH website for more information about the CAQH Proview database and application process.

Credentialing and Recredentialing
Additional CAQH Resources
Contact information for the CAQH Help Desk:

- Phone: 1-888-599-1771
- Operating hours: Monday to Thursday, 7 a.m. to 9 p.m.; Friday, 7 a.m. to 7 p.m.
- Email: providerhelp@proview.caqh.org

Please note: Providers with vision and/or hearing challenges may call the CAQH Help Desk and complete the application by phone.

Credentialing and Recredentialing
UniCare Contracting Process for Hospital or Facility-Based Providers
Hospital or facility-based providers must submit a request for contracting with and participating in the UniCare Medicaid network. If you have questions about the UniCare contracting process, please contact our Customer Care Center at 1-800-782-0095.

Eligible hospital or facility-based specialties include, but are not limited to the following:

- Anesthesiologist
- Emergency room provider
- Hospitalist
- Neonatologist
- Pathologist
- Radiologist

Hospital or facility-based providers must have the following:

- Hospital privileges
• Type 1 NPI number
• West Virginia Medical Board license (temporary permit is acceptable) or appropriate West Virginia licensure applicable to provider type
• Certificate/AANA# (applicable to Certified Nurse Anesthetist [CRNA] providers only)

Please note: Obtaining a UniCare provider record ID does not activate the Medicaid network automatically. Claims will be processed out-of-network until the provider has applied for network participation and has been approved and activated in the Medicaid network.

To complete the contracting process, hospital or facility-based providers must take the steps outlined in the following sections, as appropriate.

Medical Group Adding a Provider
If you are part of a medical group that has a Group Medicaid Agreement and this group is adding you as a facility-based provider with Medicaid: Complete the Provider Application and fax the completed application to your local Network Management office for processing.

Solo Provider or Medical Group Interested in Contracting with UniCare
If you are a solo provider or medical group interested in contracting as a facility-based provider with the Medicaid network, and you do not currently have a Medicaid Agreement, complete and sign either of the following documents:
• Solo or Medical Group Agreement (whichever is applicable)
• Provider Application

Submit the completed document to your local Network Management office.

Credentialing and Recredentialing

Credentialing Updates
You must inform CAQH and UniCare of changes to your practice. UniCare members rely on the accuracy of the information in our online UniCare Provider Finder®. CAQH will send automatic reminders for you to review and attest to the accuracy of your data every four months. If you are a participating provider, you may submit most changes online by using the Change Your Information form available at https://proview.caqh.org/pr.

Recredentialing
When you are scheduled for recredentialing, UniCare will determine if you have completed the ProView credentialing process and have authorized UniCare to access your information or if you have selected global authorization. If you have made this authorization, UniCare obtains your current information from the ProView database and completes the recredentialing process without contacting you. If your recredentialing application is not available to UniCare through CAQH for any reason, UniCare will fax you a reminder to update the application.

Please note: You must enter your changes into the ProView database and grant access to UniCare during the credentialing and recredentialing process. Only health care plans participating in the ProView database and those to which you have granted access receive these changes.
Credentialing and Recredentialing

UniCare’s Discretion

The credentialing summary, criteria, standards and requirements set forth herein are not intended to limit UniCare’s discretion in any way to amend, change or suspend any aspect of its credentialing program nor is it intended to create rights on the part of practitioners who seek to provide healthcare services to our members. UniCare further retains the right to approve, suspend, or terminate individual physicians and health care professionals and sites in those instances where it has delegated credentialing decision making.

Credentialing Scope

UniCare credentials the following licensed/state certified independent health care practitioners:

- Medical doctors (MD)
- Doctors of osteopathic medicine (DO)
- Doctors of podiatry
- Chiropractors
- Optometrists providing health services covered under the health benefits plan
- Oral maxillofacial surgeons
- Psychologists who have doctoral or master’s level training
- Clinical social workers who have master’s level training
- Psychiatric or behavioral nurse practitioners who have master’s level training
- Other behavioral health care specialists telemedicine practitioners who provide treatment services under the health benefit plan
- Medical therapists (for example, physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists, acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered dieticians

The following behavioral health practitioners are not subject to professional conduct and competence review under UniCare’s credentialing program but are subject to a certification requirement process, including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified behavioral analysts
- Certified addiction counselors
- Substance abuse practitioners

UniCare credentials the following health delivery organizations (HDOs):

- Hospitals
- Home health agencies
- Skilled nursing facilities (nursing homes)
- Ambulatory surgical centers
- Behavioral health facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings, including:
Adult family care/foster care homes
- Ambulatory detox
- Community mental health centers
- Crisis stabilization units
- Intensive family intervention services
- Intensive outpatient — mental health and/or substance abuse
- Methadone maintenance clinics
- Outpatient mental health clinics
- Outpatient substance abuse clinics
- Partial hospitalization — mental health and/or substance abuse
- Residential treatment centers — psychiatric and/or substance abuse
- Birthing centers
- Home infusion therapy when not associated with another currently credentialed HDO

The following HDOs are not subject to professional conduct and competence review under UniCare’s credentialing program but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (Clinical Laboratory Improvement Amendments [CLIA] Certification of Accreditation or CLIA Certificate of Compliance)
- End-stage renal disease (ESRD) service providers (dialysis facilities) (CMS Certification)
- Portable X-ray suppliers (FDA Certification)
- Home infusion therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally qualified health centers (FQHC) (CMS Certification)
- Rural health clinics (CMS Certification)

**Credentialing and Recredentialing**

**Credentialing Committee**
The decision to accept, retain, deny or terminate a practitioner’s participation in a network or plan program is conducted by a peer review body, known as UniCare’s Credentials Committee (CC).

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the vice president of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both commercial and Medicaid contracts exist. The chair must be a state or regional lead medical director, or a UniCare medical director designee, and the vice-chair must be a lead medical officer or an UniCare medical director designee for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than ten, external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine), surgery, or behavioral health with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health
providers (for example, nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair’s discretion. At least two of the physician committee members must be credentialed for each line of business (for example, commercial, Medicare and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/recredentialing process as needed.

The CC will access various specialists for consultation as needed to complete the review of a practitioner’s credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant’s participation, or terminate a practitioner from participation in one or more networks or plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of UniCare’s credentialing program. In particular, information supplied by the practitioner or HDO in the application, as well as other nonpublicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulating agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified they have the right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the credentialing staff will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner’s credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. On request, the practitioner will be provided with the status of their credentialing or recredentialing application.

UniCare may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.
Credentialing and Recredentialing

Nondiscrimination Policy

UniCare will not discriminate against any applicant for participation in its programs or provider network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran or marital status, or any unlawful basis not specifically mentioned herein. Additionally, UniCare will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities, which are provided to the members to meet their needs and preferences, this information is not required in the credentialing and recredentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. UniCare will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. Should discriminatory practices be identified through audit or through other means, UniCare will take appropriate action(s) to track and eliminate those practices.

Credentialing and Recredentialing

Initial Credentialing

Each practitioner or HDO must complete a standard application form deemed acceptable by UniCare when applying for initial participation in one or more of UniCare’s networks or plan programs. For practitioners, the CAQH/ProView system is utilized. To learn more about CAQH, visit their web site at https://www.caqh.org.

UniCare will verify those elements related to applicants’ legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, UniCare will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

<table>
<thead>
<tr>
<th>A. Practitioners</th>
<th>Verification Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>License to practice in the state(s) in which the practitioner will be treating covered individuals.</td>
<td></td>
</tr>
<tr>
<td>Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a network hospital previously approved by the committee.</td>
<td></td>
</tr>
<tr>
<td>DEA/CDS and state controlled substance certificates</td>
<td></td>
</tr>
<tr>
<td>The DEA/CDS certificate must be valid in the state(s) in which practitioner will be treating covered individuals. Practitioners who see covered individuals in more than one state must have a DEA/CDS certificate for each state.</td>
<td></td>
</tr>
<tr>
<td>Malpractice insurance</td>
<td></td>
</tr>
<tr>
<td>Malpractice claims history</td>
<td></td>
</tr>
<tr>
<td>Board certification or highest level of medical training or education</td>
<td></td>
</tr>
<tr>
<td>Work history</td>
<td></td>
</tr>
<tr>
<td>Verification Element</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>State or federal license sanctions or limitations</td>
<td></td>
</tr>
<tr>
<td>Medicare, Medicaid or FEHBP sanctions</td>
<td></td>
</tr>
<tr>
<td>National Practitioner Data Bank report</td>
<td></td>
</tr>
<tr>
<td>State Medicaid Exclusion Listing, if applicable</td>
<td></td>
</tr>
</tbody>
</table>

### B. HDOs

<table>
<thead>
<tr>
<th>Verification Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation, if applicable</td>
</tr>
<tr>
<td>License to practice, if applicable</td>
</tr>
<tr>
<td>Malpractice insurance</td>
</tr>
<tr>
<td>Medicare certification, if applicable</td>
</tr>
<tr>
<td>Department of Health survey results, or recognized accrediting organization certification</td>
</tr>
<tr>
<td>License sanctions or limitations, if applicable</td>
</tr>
<tr>
<td>Medicare, Medicaid or FEHBP sanctions</td>
</tr>
</tbody>
</table>

## Credentialing and Recredentialing

### Recredentialing

The recredentialing process incorporates reverification and the identification of changes in the practitioner’s or HDO’s licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner’s or HDO’s professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet UniCare credentialing standards.

During the recredentialing process, UniCare will review verification of the credentialing data as described in the tables under Initial Credentialing, unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements. In addition, UniCare will incorporate performance indicators into the recredentialing cycle. This includes any available information from internal sources such as: satisfaction survey results, UM information, complaints/grievances and other quality improvement activities.

All applicable practitioners and HDOs in the network within the scope of the UniCare credentialing program are required to be recredentialed every three years unless otherwise required by contract or state regulations.

### Site Visits

West Virginia regulations: Title 114 Legislative Rule, Insurance Commissioner Series 53, Quality Assurance

6.6. Representatives from the credentialing committee or members of their staff shall make an initial visit to each potential primary care practitioner’s office and to the offices of obstetricians/gynecologists and other high-volume specialists. This process shall include documentation of a structured review of the site and of medical record keeping practices to ensure conformance with the HMO’s standards.
7.e. The recredentialing process shall include an on-site visit to all primary care providers, obstetricians/gynecologists and high-volume specialists and shall involve documentation of a structured review of the site and medical record keeping practices to ensure conformance with HMO standards.

**Please note:** UniCare does not recognize site accreditation to be used in lieu of an office site review.

**Credentialing and Recredentialing**

**Health Delivery Organization**

New HDO applicants will submit a standardized application to UniCare for review. If the candidate meets UniCare screening criteria, the credentialing process will commence. To assess whether network HDOs, within the scope of the credentialing program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail in the UniCare Credentialing Program Standards, all network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, UniCare may evaluate the most recent site survey by Medicare or the appropriate state oversight agency performed within the past 36 months for that HDO.

Recredentialing of HDOs occur every three years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in networks or plan programs must submit all required supporting documentation.

On request, HDOs will be provided with the status of their credentialing application. UniCare may request, and will accept, additional information from the HDO to correct incomplete, inaccurate, or conflicting credentialing information. The CC will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

**Credentialing and Recredentialing**

**Ongoing Sanction Monitoring**

To support certain credentialing standards between the recredentialing cycles, UniCare has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

1. Office of the Inspector General (OIG)
2. Federal Medicare/Medicaid reports
3. Office of Personnel Management (OPM)
4. State licensing boards/agencies
5. Covered individual/customer services departments
6. Clinical Quality Management department (including data regarding complaints of both a clinical and nonclinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Other internal UniCare departments
8. Any other verified information received from appropriate sources
When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response including, but not limited to: review by the chair of the UniCare CC, review by the UniCare medical director, referral to the CC or termination. UniCare credentialing departments will report practitioners or HDOs to the appropriate authorities as required by law.

**Credentialing and Recredentialing Appeals Process**

UniCare has established policies for monitoring and recredentialing practitioners and HDOs who seek continued participation in one or more of UniCare’s networks or plan programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and UniCare may wish to terminate practitioners or HDOs. UniCare also seeks to treat Network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating participation in UniCare’s networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB). Additionally, UniCare will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only).

It is the intent of UniCare to give practitioners and HDOs the opportunity to contest a termination of the practitioner’s or HDO’s participation in one or more of UniCare’s networks or plan programs, and those denials of request for initial participation which are reported to the NPDB that were based on professional competence and conduct considerations. Immediate terminations may be imposed due to:

- The practitioner’s or HDO’s suspension or loss of licensure
- Sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs
- A criminal conviction
- UniCare’s determination that the practitioner’s or HDO’s continued participation poses an imminent risk of harm to covered individuals

A practitioner/HDO whose license has been suspended or revoked or who has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs has no right to informal review/reconsideration or formal appeal.

**Credentialing and Recredentialing Reporting Requirements**

When UniCare takes a professional review action with respect to a practitioner’s or HDO’s participation in one or more of its networks or plan programs, UniCare may have an obligation to report such to the NPDB. Once UniCare receives a verification of the NPDB report, the verification report will be sent to the state licensing board. The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.
Credentialing and Recredentialing

Credentialing Program Standards

I. Eligibility Criteria

Health care practitioners:

Initial applicants must meet all of the following criteria in order to be considered for participation:

A. Not federally sanctioned, debarred or excluded from participation in Medicare, Medicaid or FEHBP programs
B. Possess a current, valid, unencumbered, unrestricted and nonprobationary license in the state(s) where he/she provides services to covered individuals
C. Possess a current, valid and unrestricted DEA and/or CDS registration for prescribing controlled substance if applicable to his/her specialty in which he/she will treat members; the DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating members. Practitioners who see members in more than one state must have a DEA/CDS registration for each state.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

A. For MDs, DOs, DPMs and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties [ABMS], American Osteopathic Association [AOA], Royal College of Physicians and Surgeons of Canada [RCPSC], College of Family Physicians of Canada [CFPC], American Board of Foot and Ankle Surgery [ABFAS], American Board of Podiatric Medicine [ABPM], or American Board of Oral and Maxillofacial Surgery [ABOMS]) in the clinical discipline for which they are applying.
B. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
C. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Noncertified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
E. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
   a. Previous board certification (in one of the approved boards listed above) in the clinical specialty or subspecialty for which they are applying which has now expired AND a minimum of 10 consecutive years of clinical practice
   b. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty
   c. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature, and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in UniCare’s network and the applicant’s professional activities are spent at that institution at least 50% of the time.
Practitioners meeting one of these three alternative criteria (a, b, c) will be viewed as meeting all UniCare education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to UniCare review and approval. Reports submitted by the delegate to UniCare must contain sufficient documentation to support the above alternatives, as determined by UniCare.

For MDs and DOs, the applicant must have unrestricted hospital privileges at either a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), HFAP, CIHQ-accredited hospital, or a network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may, at its discretion, deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a network practitioner to provide inpatient care.

II. Criteria for Selecting Practitioners

A. New applicants (credentialing)
   1. Submission of a complete application and required attachments that must not contain intentional misrepresentations;
   2. Application attestation signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
   3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
   4. No evidence of potential material omission(s) on application;
   5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Covered Individuals;
   6. No current license action;
   7. No history of licensing board action in any state;
   8. No current federal sanction and no history of federal sanctions (per System for Award Management [SAM], OIG and OPM report nor on NPDB report);
   9. Possess a current, valid, and unrestricted DEA/CDS certificate for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals. The DEA/CDS certificate must be valid in the state(s) in which the practitioner will be treating Covered Individuals. Practitioners who treat Covered Individuals in more than one state must have a valid DEA/CDS certificate for each applicable state.
      Initial applicants who have NO DEA/CDS certificate will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he has applied for a DEA/CDS certificate, the credentialing process may proceed if all of the following are met:
         a. It can be verified that this application is pending.
         b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS certificate is obtained.
         c. The applicant agrees to notify UniCare upon receipt of the required DEA/CDS certificate.
         d. UniCare will verify the appropriate DEA/CDS certificate via standard sources.
            i. The applicant agrees that failure to provide the appropriate DEA/CDS certificate within a 90-calendar day timeframe will result in termination from the Network.
            ii. Initial applicants who possess a DEA/CDS certificate in a state other than the state in which they will be treating Covered Individuals will be notified of the need to obtain...
the additional DEA/CDS certificate. If the applicant has applied for additional DEA/CDS certificate the credentialing process may proceed if ALL the following criteria are met:
(a) It can be verified that this application is pending and,
(b) The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS certificate is obtained,
(c) The applicant agrees to notify UniCare upon receipt of the required DEA/CDS certificate,
(d) UniCare will verify the appropriate DEA/CDS certificate via standard sources; applicant agrees that failure to provide the appropriate DEA/CDS certificate within a ninety (90) calendar day timeframe will result in termination from the Network,
AND
(e) Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.

iii. Office-based practitioners who voluntarily choose to have a DEA/CDS registration that does not include all controlled substance schedules (for example, schedule II, III or IV), if that practitioner certifies that controlled substances from these schedules are not prescribed within his/her scope of practice; and he/she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances from these schedules should it be clinically appropriate; and DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;
11. No history of or current use of illegal drugs or history of or current alcoholism;
12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
13. No gap in work history greater than six (6) months in the past five (5) years with the exception of those gaps related to parental leave or immigration where twelve (12) month gaps will be acceptable. Other gaps in work history of six to twenty-four (6 to 24) months will be reviewed by the chair of the CC and may be presented to the CC if the gap raises concerns of future substandard professional conduct and competence. In the absence of this concern the chair of the CC may approve work history gaps of up to two (2) years.
14. No history of criminal/felony convictions or a plea of no contest;
15. A minimum of the past ten (10) years of malpractice case history is reviewed.
16. Meets credentialing standards for education/training for the specialty(ies) in which practitioner wants to be listed in UniCare’s network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
17. No involuntary terminations from an HMO or PPO;
18. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
   a. investment or business interest in ancillary services, equipment or supplies;
   b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
   c. voluntary surrender of state license related to relocation or nonuse of said license;
d. an NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria.

e. non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business);

f. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the 5-year post-residency training window;

g. actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion;

h. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Practitioners who meet all participation criteria for initial or continued participation and whose credentials have been satisfactorily verified by the Credentialing department may be approved by the chair of the CC after review of the applicable credentialing or recredentialing information. This information may be in summary form and must include, at a minimum, practitioner’s name and specialty.

B. Currently participating applicants (recredentialing)

1. Submission of complete recredentialing application and required attachments that must not contain intentional misrepresentations;

2. Recredentialing application signed and dated within 180 calendar days of the date of submission to the CC for a vote;

3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP. If, once a practitioner participates in UniCare’s programs or provider network(s), federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider network(s) as well as UniCare’s other credentialed provider network(s);

4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to members;

5. No new history of licensing board reprimand since prior credentialing review;

6. No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM reports or on NPDB report);

7. Current DEA/CDS registration and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;

8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a network practitioner of similar specialty at a network HDO who provides inpatient care to members needing hospitalization;

9. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
10. No impairment or other condition that would negatively impact the ability to perform the essential functions in their professional field;

11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;

12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used;

13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;

14. No new (since previous credentialing review) yes answers on attestation/disclosure questions with exceptions of the following:
   a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
   b. Voluntary surrender of state license related to relocation or nonuse of said license;
   c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
   d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business);
   e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five year post-residency training window;
   f. Actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion;
   g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

15. No QI data or other performance data including complaints above the set threshold. Recredentialing at least every three years to assess the practitioner’s continued compliance with UniCare standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed network practitioners and HDOs that do not meet one or more of the criteria for recredentialing.

C. Additional participation criteria and exceptions for behavioral health practitioners (nonphysician), nurse practitioners and nurse midwives; all other applicable credentialing and recredentialing criteria needs to be met in addition to these items:
   1. Licensed clinical social workers (LCSW and ILSW) or other master level social work license type:
      a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education (CSWE) or the Canadian Association on Social Work Education (CASWE).
      b. Program must have been accredited within three years of the time the practitioner graduated.
c. Full accreditation is required, candidacy programs will not be considered.
d. If master’s level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the American Psychological Association (APA) or be regionally accredited by the Council for Higher Education Accreditation (CHEA). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

2. Licensed professional counselor (LPC) and marriage and family therapist (MFT) or other master level license type:
   a. Master’s or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
   b. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
   c. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs (CACREP), or Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) listings. The institution must have been accredited within three years of the time the practitioner graduated.
   d. Practitioners with PhD training as a clinical psychologist can be reviewed. To meet criteria, this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. A practitioner with a doctoral degree in one of the fields of study noted will be viewed as acceptable if the institution granting the degree has regional accreditation from the CHEA.
   e. Licensure to practice independently.

3. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
   a. Master’s degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three years of the time of the practitioner’s graduation.
   b. Registered nurse license and any additional licensure as an advanced practice nurse/certified nurse specialist/adult psychiatric nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
   c. Certification by the American Nurses Association (ANA) in psychiatric nursing. This may be any of the following types: clinical nurse specialist in child or adult psychiatric nursing, psychiatric and mental health nurse practitioner, or family psychiatric and mental health nurse practitioner.
   d. Valid, current, unrestricted DEA/CDS certificate, where applicable with appropriate supervision/consultation by a network practitioner as applicable by the state licensing board. For those who possess a DEA certificate, the appropriate CDS certificate is required. The DEA/CDS certificate must be valid in the state(s) in which the practitioner will be treating covered individuals.
4. Clinical psychologists:
   a. Valid state clinical psychologist license.
   b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three years of the time of the practitioner’s graduation.
   c. Education/training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a diplomat of the American Board of Professional Psychology.
   d. Master’s level therapists in good standing in the network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the network and will not be subject to the above education criteria.

5. Clinical neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in C.4 above and be board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN).
   b. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.
   c. Clinical neuropsychologists, who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      i. Transcript of applicable predoctoral training OR
      ii. Documentation of applicable formal one year post-doctoral training (participation in CEU training alone would not be considered adequate) OR
      iii. Letters from supervisors in clinical neuropsychology (including number of hours per week) OR
      iv. Minimum of five years’ experience practicing neuropsychology at least 10 hours per week

6. Licensed psychoanalysts:
   a. This applies only to practitioners in states that license psychoanalysts.
   b. Practitioners will be credentialed as a licensed psychoanalyst if they aren’t otherwise credentialed as a practitioner type, as detailed in the credentialing policy (e.g., psychiatrist, clinical psychologist, licensed clinical social worker).
   c. The practitioner must possess a valid psychoanalysis state license.
      i. The practitioner shall possess a master’s or higher degree from a program accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Postsecondary Education, American Psychological Association (APA), Council for Accreditation of Counseling & Related Educational Programs (CACREP) or the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) listings. The institution must have been accredited within three years of the time the practitioner graduates.
      ii. The practitioner shall complete a program in psychoanalysis that is registered by the licensing state as licensure-qualifying, accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another
acceptable accrediting agency, or determined by the licensing state to be the substantial equivalent of such a registered or accredited program.

1. A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the licensing state determines that it:
   a. Prepares individuals for the professional practice of psychoanalysis
   b. Is recognized by the appropriate civil authorities of that jurisdiction
   c. Can be appropriately verified
   d. Is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure-qualifying or accredited program

2. The practitioner must meet the minimum supervised experience requirement for licensure as a psychoanalyst, as determined by the licensing state.

3. The practitioner must meet the examination requirements for licensure, as determined by the licensing state.

D. Process, requirements and verification for nurse practitioners:

1. The nurse practitioner applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.

2. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the licensing agency or certification board does not verify the highest level of education, the education will be primary source verified in accordance with policy.

3. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

4. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal UniCare procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.

5. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
   a. Certification program of the American Nurse Credentialing Center (www.nursecredentialing.org), a subsidiary of the American Nursing Association (http://www.nursingcertification.org); or
   b. American Academy of Nurse Practitioners Certification Program (https://www.aanpcert.org); or
c. National Certification Corporation (https://www.nccwebsite.org); or
d. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse (CPN) Practitioner (note: CPN is not a nurse practitioner) (https://www.pncb.org/pncb-exams); or
e. Oncology Nursing Certification Corporation (ONCC) Advanced Oncology Certified Nurse Practitioner (AOCNP®) only (http://oncc.org);
f. American Association of Critical Care Nurses (https://www.aacn.org/certification/verify-certification); Adult Care Nurse Practitioner (ACNPC). This certification must be active and primary source verified; ACNPC-AG — Adult Gerontology Acute Care. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by UniCare is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

6. If the NP has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee.

E. Process, requirements and verifications for certified nurse midwives:
1. The certified nurse midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
2. The required educational/training will be at a minimum required for licensure as a RN with subsequent additional training for licensure as a CNM by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
3. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
4. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal UniCare procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
5. All CNM applicants will be certified by either:
   a. The National Certification Corporation for OB/GYN and Neonatal Nursing; or
   b. The American Midwifery Certification Board, previously known as the American College of Nurse Midwives.
   c. This certification must be active and primary source verified. If the state licensing board primary source verifies one of these certifications as a requirement for licensure, additional verification by UniCare is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.
6. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO or HFAP accredited hospital, or a network hospital previously approved by the committee, or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a level II review. Should the CNM provide only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/GYN.

7. The CNM applicant will undergo the standard credentialing process outlined in UniCare’s Credentialing Policies. CNMs are subject to all the requirements of these Credentialing Policies including (but not limited to): the requirement for committee review for level II applicants; recredentialing every three years; and continuous sanction and performance monitoring on participation in the network.

8. Upon completion of the credentialing process, the CNM may be listed in UniCare’s provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

9. CNMs will be clearly identified as such:
   - On the credentialing file.
   - At presentation to the CC.
   - On notification to Network Services and to the provider database.

F. Process, requirements and verifications for physician’s assistants (PA):
   1. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
   2. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
   3. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid, will be notified of this and the applicant will be administratively denied.
   4. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal UniCare procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
   5. All PA applicants will be certified by the National Commission on Certification of Physician’s Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by UniCare is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a level II according to geographic Credentialing Policy 8 and submitted for individual review by the CC.
   6. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee.
Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.

7. The PA applicant will undergo the standard credentialing process outlined in UniCare’s Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies, including (but not limited to): committee review of level II files failing to meet predetermined criteria; recredentialing every three years; and continuous sanction and performance monitoring on participation in the network.

8. Upon completion of the credentialing process, the PA may be listed in UniCare provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

9. PA’s will be clearly identified such:
   • On the credentialing file.
   • At presentation to the CC.
   • On notification to Network Services and to the provider database.

III. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, UniCare may evaluate the most recent site survey by Medicare or the appropriate state oversight agency performed within the past 36 months. Nonaccredited HDOs are subject to individual review by the CC and will be considered for covered individual access need only when the CC review indicates compliance with UniCare standards, and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality, care or patient safety. HDOs are recredentialed at least every three years to assess the HDO’s continued compliance with UniCare standards.

A. General criteria for HDOs:
   1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to covered individuals (the license must be in good standing with no sanctions)
   2. Valid and current Medicare certification
   3. Must not be currently debarred or excluded from participation in any Medicare, Medicaid of FEHBP programs
      o Note: If, once an HDO participates in UniCare’s programs or provider network(s), exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification the HDO will become immediately ineligible for participation in the applicable government programs or provider network(s), as well as UniCare’s other credentialed provider network(s).
   4. Liability insurance acceptable to UniCare

If not appropriately accredited, the HDO must submit a copy of its CMS or state site survey for review by the CC, to determine if UniCare’s quality and certification criteria standards have been met.

B. Additional participation criteria for HDOs by provider type:

<table>
<thead>
<tr>
<th>MEDICAL FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility type (medical care)</td>
</tr>
<tr>
<td>Acute care hospital</td>
</tr>
<tr>
<td>Facility type (medical care)</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Ambulatory surgical center</td>
</tr>
<tr>
<td>Birthing center</td>
</tr>
<tr>
<td>Home health care agency (HHA)</td>
</tr>
<tr>
<td>Home infusion therapy (HIT)</td>
</tr>
<tr>
<td>Skilled nursing facility/nursing homes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility type (BH care)</th>
<th>Acceptable accrediting agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care hospital — psychiatric disorders</td>
<td>CTEAM, DNV/NIAHO, TJC, HFAP</td>
</tr>
<tr>
<td>Adult family care home (AFCH)</td>
<td>ACHC, TJC</td>
</tr>
<tr>
<td>Adult foster care</td>
<td>ACHC, TJC</td>
</tr>
<tr>
<td>Community mental health center (CMHC)</td>
<td>AAAHC, CARF, CHAP, COA, TJC</td>
</tr>
<tr>
<td>Crisis stabilization unit</td>
<td>TJC</td>
</tr>
<tr>
<td>Intensive family intervention services</td>
<td>CARF</td>
</tr>
<tr>
<td>Intensive outpatient — mental health and/or substance abuse</td>
<td>ACHC, DNV/NIAHO, TJC, COA, CARF</td>
</tr>
<tr>
<td>Outpatient mental health clinic (includes licensed BH clinics)</td>
<td>HFAP, TJC, CARF, COA, CHAP</td>
</tr>
<tr>
<td>Partial hospitalization/day treatment — psychiatric disorders and/or substance abuse</td>
<td>CARF, DNV/NIAHO, HFAP, TJC</td>
</tr>
<tr>
<td>Residential treatment center (RTC) — psychiatric disorders and/or substance abuse</td>
<td>DNV/NIAHO, TJC, HFAP, CARF, COA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility type (BH care)</th>
<th>Acceptable accrediting agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute inpatient hospital — detoxification only facilities</td>
<td>DNV/NIAHO, HFAP, TJC, CTEAM</td>
</tr>
<tr>
<td>Behavioral health ambulatory detox</td>
<td>CARF, TJC</td>
</tr>
<tr>
<td>Methadone maintenance clinic</td>
<td>CARF, TJC, COA</td>
</tr>
<tr>
<td>Outpatient substance abuse clinics</td>
<td>CARF, TJC</td>
</tr>
</tbody>
</table>
CHAPTER 14: ACCESS STANDARDS AND ACCESS TO CARE

Access Standards and Access to Care
Overview
This chapter outlines UniCare’s standards for timely and appropriate access to quality health care. Following guidelines set by the National Committee for Quality Assurance (NCQA), the American College of Obstetricians and Gynecologists (ACOG), and the West Virginia Bureau for Medical Services (BMS), these standards help ensure that medical appointments, emergency services and continuity of care for our members are provided fairly, reasonably and within specific time frames.

We recognize that cultural and linguistic barriers may affect our members’ ability to understand or comply with certain instructions or procedures. To break through those barriers and ensure that our access standards can be met, we encourage providers to take advantage of UniCare’s Cultural Competency Training and Cultural and Linguistic Toolkit called Caring for Diverse Populations. We have included an introduction to this training in Chapter 22: Cultural Diversity and Linguistic Services. Locate the complete training program and toolkit in the Health Education section on the Provider Resources page of our website at www.unicare.com and select Cultural Competency Training and Caring for Diverse Populations. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

UniCare encourages providers to attend training in an effort to promote sensitivity to the special needs of the Medicaid population. UniCare supports continuous education through webinars, town hall meetings and provider orientations.

UniCare monitors provider compliance with access to care standards on a regular basis. Failure to comply may result in corrective action.

Access Standards and Access to Care
General Appointment Scheduling
PCPs and specialists must make appointments for members from the time of request according to the following guidelines:

<table>
<thead>
<tr>
<th>Nature of visit</th>
<th>Appointment standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency examinations</td>
<td>Immediate access during office hours</td>
</tr>
<tr>
<td>Urgent examinations</td>
<td>Within 48 hours of request</td>
</tr>
<tr>
<td>Nonurgent “sick visits”</td>
<td>Within 72 hours of request</td>
</tr>
<tr>
<td>Nonurgent routine examinations*</td>
<td>Within 21 days of member’s request</td>
</tr>
<tr>
<td>Adult baseline and routine physical</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>Specialty care examinations</td>
<td>Within two weeks of request for routine referrals; within 24 hours for urgent referrals</td>
</tr>
<tr>
<td>Outpatient behavioral health examinations</td>
<td>Within 14 days of request</td>
</tr>
<tr>
<td>Routine behavioral health visits</td>
<td>Within 10 days of request</td>
</tr>
<tr>
<td>Outpatient treatment</td>
<td>Within seven days of discharge</td>
</tr>
<tr>
<td>Post-psychiatric inpatient care</td>
<td>Within seven days of discharge</td>
</tr>
</tbody>
</table>
*Exceptions are permitted for routine cases, other than clinical preventive services, when PCP capacity is temporarily limited.

**Access Standards and Access to Care**

**Services for Members**

UniCare strongly recommends that PCPs perform an initial health assessment (IHA) and preventive care assessment with new members.

**Please note:** An IHA is not needed if the member is an existing patient of the PCP group but new to UniCare. In addition, follow-up is not needed if there is an established medical record that shows baseline health status. This record should include sufficient information for the PCP to understand the member’s health history and to provide treatment recommendations as needed. Transferred medical records meet the recommendations for an IHA if a completed health history is included.

<table>
<thead>
<tr>
<th>Nature of visit</th>
<th>Appointment standards</th>
</tr>
</thead>
</table>
| IHAs                     | Newborns: Within 30 days of birth  
Children (ages 0-18): Within 60 days of enrollment  
Adults (ages 18 and older): Within 90 days of enrollment |
| Preventive care visits   | According to the American Academy of Pediatrics (AAP) periodicity schedule found within the preventive health care guidelines |

**Access Standards and Access to Care**

**Prenatal and Postpartum Visits**

Providers must make prenatal and postpartum appointments for members from the time of request according to the following guidelines:

<table>
<thead>
<tr>
<th>Nature of visit</th>
<th>Appointment standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>First trimester</td>
<td>Within 14 calendar days of request</td>
</tr>
<tr>
<td>Second trimester</td>
<td>Within 7 calendar days of request</td>
</tr>
<tr>
<td>Third trimester</td>
<td>Within 3 business days of request or immediately if an emergency</td>
</tr>
<tr>
<td>High-Risk pregnancy</td>
<td>Within 3 business days of request or immediately if an emergency</td>
</tr>
<tr>
<td>Postpartum examination</td>
<td>Between 3 and 8 weeks after delivery</td>
</tr>
</tbody>
</table>

**Access Standards and Access to Care**

**Missed Appointment Tracking**

When a member misses an appointment, providers must do the following:

- Document the missed appointment in the member’s medical record.
- Make at least three attempts to contact the member to determine the reason for the missed appointment.
- Provide a reason in the member’s medical record for any delays in performing an examination, including any refusals by the member.
Access Standards and Access to Care

After-Hours Services

Our members have access to quality health care 24 hours a day, 7 days a week. This means that PCPs must have a system in place to ensure members may call after-hours with medical questions or concerns. UniCare monitors PCP compliance with after-hours access standards on a regular basis. We recommend that PCPs advise their answering services to participate in any after-hours monitoring. Failure to comply may result in corrective action. PCPs must adhere to the answering service and answering machine protocols defined in the following sections.

Answering Service

Answering service or after-hours personnel must:

- Ask the member if the call is an emergency. In the event of an emergency, direct the member to dial 911 immediately or proceed directly to the nearest hospital emergency room.
- Forward nonemergency member calls directly to the PCP or on-call provider or instruct the member that the provider will be in contact within 30 minutes.
- Have the ability to contact a telephone Interpreter to assist members with language barriers.
- Return all calls.

Members may call the 24/7 NurseLine any time of the day or night to speak to a registered nurse. 24/7 NurseLine nurses provide health information and options for accessing care, including emergency services, if appropriate.

Answering Machines

Answering machine messages:

- May be used when provider office staff or an answering service is not immediately available.
- Must instruct members with emergency health care needs to dial 911 or proceed directly to the nearest hospital emergency room.
- Must provide instructions on how to contact the PCP or on-call provider in a nonemergency situation.
- Must provide instructions in English, Spanish and any other language appropriate to the PCP’s practice.

We offer the following suggested text for answering machines:

“Hello, you have reached [insert Physician office name]. If this is an emergency, hang up and dial 911 or go to the nearest hospital emergency room. If this is not an emergency and you have a medical concern or question, please call [insert contact phone or pager number]. You will receive a return call from the on-call physician within [time frame].”

Please note: UniCare has implemented a system to report difficulties experienced with the 24/7 NurseLine, emergency care systems, or protocol failures. To report failures, contact the Customer Care Center at 1-800-782-0095. Corrective action plans will be requested from contracted network hospitals with emergency departments that fail to meet the department/emergency room protocols.

Please note: UniCare prefers that PCPs use a UniCare-contracted, in-network provider for on-call services. When this is not possible, the PCP must use his or her best efforts to ensure the on-call provider abides by the terms of the UniCare provider contract.
Access Standards and Access to Care

Continuity of Care

UniCare provides continuity of care for members with qualifying conditions when health care services are not available within the network or when the member or provider is in a state of transition.

Qualifying condition: A medical condition that may qualify a member for continued access to care and continuity of care. These conditions include, but are not limited to:

- Acute conditions (cancer, for example)
- Degenerative and disabling conditions or diseases caused by a congenital or acquired injury or illness requiring a specialized rehabilitation program or a high level of service, resources or coordination of care in the community
- Newborns, who are covered retroactive to the date of birth
- Organ transplant or tissue replacement
- Pregnancy, with 12 weeks or less remaining before the expected delivery date, through immediate postpartum care
- Scheduled inpatient/outpatient surgery that was approved and/or precertified through the applicable BMS process
- Serious chronic conditions (hemophilia, for example)
- Terminal illness

States of transition may be when the member is:

- Newly enrolled
- Moving out of the service area
- Disenrolling from UniCare to another health plan
- Exiting UniCare to receive excluded services
- Hospitalized on the effective date of transition
- Transitioning through behavioral health services
- Undergoing the West Virginia Preadmission Screening/Resident Review Screening for long-term care placement
- Scheduled for appointments within the first month of plan membership with specialists. These appointments must have been scheduled prior to the effective date of membership.

A state of transition is also applicable when the provider’s contract terminates.

UniCare providers help ensure continuity and coordination of care through collaboration. This includes the confidential exchange of information between PCPs and specialists as well as behavioral health providers. In addition, UniCare coordinates care when the provider’s contract has been discontinued to facilitate a smooth transition to a new provider.

Providers must maintain accurate and timely documentation in the member’s medical record, including, but not limited to:

- Consultations
- Prior authorizations
- Referrals to specialists
- Treatment plans
All providers share responsibility in communicating clinical findings, treatment plans, prognosis and the member’s psychosocial condition as part of the coordination process. Care management nurses review member and provider requests for continuity of care. These nurses facilitate continuation with the current provider until a short-term regimen of care is completed, or the member transitions to a new provider.

Adverse determination decisions are sent in writing to the member and provider within two business days of the decision. Members and providers may appeal the decision by following the procedures in Chapter 12: Grievances and Appeals. Reasons for continuity of care denials include, but are not limited to:

- Course of treatment is complete
- Member is ineligible for coverage
- Condition is not a qualifying condition
- Request is for a change of PCP only and not for continued access to care
- Request is for services that are not covered
- Services rendered are covered under a global fee
- Treating provider currently is contracted with the UniCare network

Please note: UniCare does not impose any pre-existing condition limitations on its members, nor require evidence of insurability to provide coverage to any UniCare member.

Access Standards and Access to Care

Provider Contract Termination

UniCare will arrange for continuity of care for members affected by a provider whose contract has terminated. The provider must notify members 60 days prior to the final date of termination. A terminated provider who is actively treating members must continue treatment for a period of at least 90 days after the date on which notice is given.

After UniCare receives a provider’s notice to terminate a contract, we will make our best effort to notify all impacted members. A letter will be sent at least 30 days in advance to inform the affected members about:

- The impending termination of the provider
- The member’s right to request continued access to care
- The Customer Care Center’s phone number. The Customer Care Center can make PCP changes and/or forward referrals to Case Management for continued access to care consideration

Members under the care of specialists may submit requests for continued access to care, including continued care after the transition period. Members should contact the Customer Care Center at 1-800-782-0095.

Access Standards and Access to Care

Newly Enrolled

Our goal is to ensure that the health care of our newly enrolled members is not disrupted or interrupted. UniCare ensures continuity in the care of our newly enrolled members when the:

- Member’s health or behavioral health condition has been treated by specialists
• Member’s health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted

UniCare will pay a newly-enrolled member’s existing out-of-network provider for medically necessary covered services until that regimen of care is completed. Then, the member’s records, clinical information and care are transferred to a UniCare provider.

Payment to out-of-network providers is made within the same time period required for providers within the network. In addition, we will comply with out-of-network provider reimbursement rules as adopted by the BMS. However, we are not obligated to reimburse the member’s existing out-of-network providers for ongoing care if it has been greater than:
• 90 days after the member enrolled in UniCare
• Nine months after the member enrolled in UniCare when, at the time of enrollment in our plan, the member was diagnosed with and receiving treatment for a terminal illness and remains enrolled in UniCare

All new enrollees receive the Member Handbook and Evidence of Coverage (EOC) membership information in their enrollment packets, which provides information regarding members’ rights to request continuity of care.

Access Standards and Access to Care
Members Moving Out of Service Area
If a member moves out of the service area, UniCare will provide services and pay out-of-network providers for the specific period of time left for which capitation on the member has been paid. For example, if a member’s capitation covers the month of June, UniCare will provide and pay for medically necessary covered services through the end of June.

Access Standards and Access to Care
Services Not Available Within Network
UniCare will provide members with timely and adequate access to out-of-network services for as long as those services are necessary and not available within the network. However, UniCare is not obligated to provide members with access to out-of-network services if such services become available from a network provider.

When a provider refers a member to another provider for additional treatment or services, the referring provider must forward notification of his/her NPI and the member’s eligibility. UniCare has streamlined this process by providing a Record of Referral to Specialty Care form, located in the Forms and Tools section of the Provider Resources page on our website at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

The referring PCP and the specialist perform the following:
• The PCP completes and faxes the form to the specialist, notifying the specialist of the PCP’s NPI.
• If the referring PCP does not provide the NPI, the specialist is responsible for contacting the PCP’s office to obtain the NPI.
• The member must be made aware that the provider they are being referred to is in-network or out-of-network.

Please note: Referrals are valid for as long as the member is under the care of the specialist.

Access Standards and Access to Care
Second Opinions
UniCare will help ensure that members have access to a second opinion regarding any medically necessary covered service. Members will be allowed access to a second opinion from a network provider, or, if a network provider is not available, from an out-of-network provider. This service is provided at no cost to the member.

Access Standards and Access to Care
Emergency Transportation
UniCare covers emergency transportation services without prior authorization. When a member’s condition is life-threatening and requires the use of special equipment, life support systems and close monitoring by trained attendants while en route to the nearest appropriate facility, we will provide emergency transport by ambulance.

Examples of conditions considered for emergency transport include, but are not limited to:
• Acute and severe illnesses
• Acute or severe injuries from auto accidents
• Extensive burns
• Loss of consciousness
• Semi-consciousness, having a seizure, or receiving cardiopulmonary resuscitation (CPR) treatment during transport
• Untreated fractures

Emergency transportation is available for facility-to-facility transfers when the required emergency treatment is not available at the first facility.

Access Standards and Access to Care
Nonemergency Transportation
Nonemergency transportation is not a covered service for UniCare. All nonemergency transportation is covered by the state of West Virginia through its fee-for-service program. Visit the West Virginia Bureau for Medical Service website for additional information at www.dhhr.wv.gov/bms/Pages/default.aspx.

Access Standards and Access to Care
Emergency Dental Services for Adults
When a member has an accident and the treatment is the first repair of an injury to the jaw, sound natural teeth, mouth or face, UniCare covers the initial dental work and oral surgery, including anesthesia and drugs, for services provided in the following settings:
• Outpatient
• Doctor’s office
• Emergency care
• Urgent care

The services are limited to the care needed to give proper treatment. Injury as a result of chewing or biting is not considered an accidental injury. Initial dental work refers to services provided within 48 hours of the injury, or as soon as possible. Covered services include all exams and treatment to complete the repair, such as:

• Anesthesia
• Lab tests
• Mandibular/maxillary reconstruction
• Oral exams
• Oral surgery
• Prosthetic services
• Restorations
• X-rays
CHAPTER 15: PROVIDER ROLES AND RESPONSIBILITIES

Provider Roles and Responsibilities
Overview
At UniCare, our goal is to provide quality health care to the right member, at the right time, in the appropriate setting. To achieve this goal, PCPs, specialists and ancillary providers must fulfill your roles and responsibilities with the highest integrity. We rely on your extensive health care education, experience, and dedication to our members, who look to you to get well and stay well.

As required by 42 CFR 438.602(b), all participating providers that order, refer or render covered services must enroll with the Department through the fiscal agent as a Medicaid provider. Enrollment with the Department does not obligate participating providers to offer services under the Fee-for-Service delivery system. UniCare is not required to contract with a provider enrolled with the Department that does not meet our credentialing or other requirements.

Provider Roles and Responsibilities
Primary Care Providers
PCPs are the principle point of contact for our members. The PCP’s role is to provide members with a medical home, the member’s first stop in the health care process and a centralized hub for a wide variety of ongoing health care needs. UniCare furnishes each PCP with a current list of enrolled members assigned to that PCP. The PCP’s role is to:

- Coordinate members’ health care 24 hours a day, 7 days a week
- Develop members’ care and treatment plans, including preventive care
- Maintain members’ current medical records, including documentation of all services provided by the PCP and any specialty or referral services
- Adhere to wait times, as outlined within the provider contract and the provider manual
- Refer members for specialty care
- Coordinate with outpatient clinical services
- Provide complete information about proposed treatments and prognosis for recovery to our members or their representatives
- Facilitate interpreter services by presenting information in a language that our members or their representatives can understand
- Ensure that members’ medical and personal information is kept confidential, as required by state and federal laws
- Obtain signed consent before providing care
- Facilitate adherence to the EPSDT periodicity schedule

The PCP’s scope of responsibilities includes providing or arranging for:

- Routine and preventive health care services
- Emergency care services
- Hospital services
- Ancillary services
- Interpreter services

Customer Care Center phone: 1-800-782-0095
Customer Care Center fax: 1-888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.
• Referrals for specialty services
• Coordination with outpatient clinical services, such as therapeutic, rehabilitative or palliative services

Please note: Services should be provided without regard to race, religion, sex, color, national origin, age, or physical/behavioral health status.

UniCare keeps providers up-to-date with detailed member information. We also furnish each PCP with a current list of assigned members and provide medical information about the members’ potential health care needs. Providers may use this information to provide care and coordinate services more effectively. PCPs should provide services only to those UniCare members who have chosen you as their PCP. Verify that a member is assigned to you by using the following methods:
• Call UniCare’s Customer Care Center at 1-800-782-0095:
  o Use the Interactive Voice Response (IVR) system
  o Speak to a Customer Service representative
• Go to https://www.availity.com and select Login to enter the secure provider portal. Then, log in to the provider online reporting tool to view the monthly PCP rosters.

You may experience delays in claims payments if you treat members who are not assigned to you on the date of service. If you must provide services to a UniCare member not assigned to you, obtain prior authorization first. If you are a noncontracted provider, you must obtain prior authorization before treating UniCare members.

Provider Roles and Responsibilities

Referrals

PCPs coordinate and make referrals to specialists, ancillary providers and community services. Providers should refer members to network facilities and providers. When network facilities and providers are not available, providers should follow the appropriate process for requesting out-of-network referrals.

Please note: Specialty referrals to in-network providers do not require prior authorization.

All PCPs must perform the following with regard to referrals:
• Help members schedule appointments with other health care providers, including specialists.
• Track and document appointments, clinical findings, treatment plans and care received by members referred to specialists or other health care providers.
• Refer members to health education programs and community resource agencies, when appropriate.
• Coordinate with the Women, Infants and Children (WIC) program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin.
• Coordinate with the local tuberculosis (TB) control program to ensure that all members with confirmed or suspected TB have a contact investigation and receive directly observed therapy (DOT).
• Report to the West Virginia Bureau for Medical Services (BMS) or the local TB control program any member who is noncompliant, drug resistant, or who is or potentially may become a public health threat.
• Screen and perform evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.
Provider Roles and Responsibilities

Out-Of-Network Referrals
We recognize that an out-of-network referral may be justified at times. UniCare’s Utilization Management (UM) department will work with the PCP to determine medical necessity and will authorize out-of-network referrals on a limited basis. For assistance, contact the UM department at 1-866-655-7423. Hours of operation are Monday to Friday, 8 a.m. to 5 p.m.

Provider Roles and Responsibilities

Interpreter Services
Providers must notify members of the availability of interpreter services from UniCare. Providers should strongly discourage the use of friends and family members, especially children, acting as interpreters. Multilingual staff should carefully self-assess their non-English language speaking and comprehension skills prior to interpreting on the job. You may find the current recommended employee language skills self-assessment tool in the Health Education section on the Provider Resources page of our website at www.unicare.com (select Employee Language Skills Self-Assessment Tool). For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

For those instances when you cannot communicate with a member due to language barriers, interpreter services are available at no cost to you or the member. Face-to-face Interpreters for members needing language assistance, including American Sign Language, are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required.

• To request interpreter services, call UniCare’s Customer Care Center at 1-800-782-0095.
• To request interpreter services after hours or TTY and Relay services, call the 24/7 NurseLine at 1-888-850-1108.
• For TTY assistance during business hours, call UniCare’s Customer Care Center TTY line at 1-866-368-1634.

Provider Roles and Responsibilities

Initial Health Assessment
PCPs are should review their monthly eligibility list provided by UniCare and determine which members are newly enrolled since the last report. PCPs should proactively contact their assigned members to make an appointment for an initial health assessment (IHA) within 90 days of enrollment. The PCP’s office is responsible for making contact with assigned members and documenting all attempts to do so. Members’ medical records must reflect the reason for any delays in performing the IHA, including any refusals by the member to have the exam.

Provider Roles and Responsibilities

Transitioning Members between Medical Facilities and Home
When medically indicated, PCPs initiate or assist with the discharge or transfer of members:

• From an inpatient facility to the appropriate skilled nursing or rehabilitation facility, or to the member’s home
• From an out-of-network hospital to an in-network hospital, or to the member’s home with home health care assistance (within benefit limits)
The coordination of member transfers from noncontracted, out-of-network facilities to contracted, in-network facilities is a priority that may require the immediate attention of the PCP. To obtain assistance, contact UniCare’s UM department at 1-866-655-7423.

Provider Roles and Responsibilities

Noncovered Services
All PCPs must inform members of the costs associated with noncovered services prior to rendering the noncovered services. For more information, call our Customer Care Center at 1-800-782-0095. Also refer to the Private Pay Agreement section of this manual.

Specialists
Specialists, licensed with additional training and expertise in a specific field of medicine, supplement the care given by PCPs. Specialists are charged with the same responsibilities as PCPs, including the responsibility of ensuring that prior authorization has been obtained before rendering services. Access to specialty care begins when the PCP refers a member to a specialist for medically necessary conditions beyond the PCP’s scope of practice. Specialists diagnose and treat conditions specific to their area of expertise.

Please note: Specialty care is limited to UniCare benefits.

The following guidelines are in place for specialists:
- For urgent care, the specialist should see the member within 24 hours of receiving the request.
- For routine care, the specialist should see the member within two weeks of receiving the request.

In some cases, a member may self-refer to a specialist. These cases include, but are not limited to:
- Family planning and evaluation
- Diagnosis, treatment and follow-up of sexually transmitted infections (STIs)
- Initial behavioral health evaluation

For some medical conditions, the specialists should be the PCP. Members may request the specialist be assigned as the PCP if the member:
- Has a chronic illness
- Has a disabling condition
- Is a child with special health care needs

Hospital Scope of Responsibilities
PCPs refer members to UniCare-contracted network hospitals for medically necessary conditions beyond the PCP’s scope of practice. Hospital care is limited to plan benefits. Hospital providers diagnose and treat conditions specific to their area of expertise. Hospital responsibilities include:
- Notification of admission and services
- Notification of preservice review decision

Refer to the following sections for specific information.
Notification of Admission and Services
The hospital must notify UniCare or the review organization of an admission or service at the time the Member is admitted or the service is rendered. If the member is admitted or a service is rendered on a day other than a business day, the hospital must notify UniCare the morning of the next business day.

Notification of Preservice Review Decision
The utilization management guidelines and the hospital agreement require that a hospital receive notice of a preservice review determination at the time of a scheduled admission or service. If this does not occur, the hospital should contact UniCare and request the status of the decision. Any admission or service requiring preservice review that has not received the appropriate review may be subject to post-service review denial. Generally, the provider is required to perform all preservice review functions with UniCare. Before services are rendered, the hospital must ensure the preservice review has been performed. If the preservice review has not been performed, the hospital risks post-service denial.

Provider Roles and Responsibilities
Ancillary Scope of Responsibilities
PCPs and specialists refer members to plan-contracted network ancillary providers for medically necessary conditions beyond the PCP’s or specialist’s scope of practice. Ancillary providers diagnose and treat conditions specific to their area of expertise. Ancillary care is limited to plan benefits. We have a wide network of participating health care providers and facilities. All services offered by the health care provider, and for which the health care provider is responsible, are listed in the ancillary agreement.

Provider Roles and Responsibilities
Responsibilities Applicable to All Providers
The following responsibilities, described below, are applicable to all UniCare providers include:

- After-hours services
- Disenrollees
- Eligibility verification
- Collaboration
- Confidentiality
- Continuity of care
- Licenses and certifications
- Mandatory reporting of abuse
- Medical records standards and documentation
- Office hours
- Open clinical dialog/affirmative statement
- Oversight of non-physician practitioners
- Preservice reviews
- Prohibited activities
- Provider contract terminations
- Termination of ancillary provider/patient relationship
- Updating provider information
Provider Roles and Responsibilities

Office Hours
To maintain continuity of care, providers’ office hours must be clearly posted and members must be informed about the providers’ availability at each site. There are strict guidelines for ensuring access to health care 24 hours a day, 7 days a week:
- Providers must be available 24 hours a day by telephone.
- An on-call provider must be available to take calls when the member’s provider is not available.

Provider Roles and Responsibilities

After-Hours Services
All PCPs must have an after-hours system in place to ensure that our members can call with medical concerns or questions after normal office hours. The answering service or after-hours personnel must forward member calls directly to the PCP or on-call physician, or instruct the member that the provider will be in contact within 30 minutes. UniCare will monitor PCP compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action. For additional information, refer to the After-Hours Services section of this manual.

Emergencies
The answering service or after-hours personnel must ask the member if the call is an emergency. In the event of an emergency, the member must be directed to dial 911 immediately or proceed to the nearest hospital emergency room.

If the PCP’s staff or answering service is not available, an answering machine may be used. The answering machine message must instruct members who have emergency health care needs to dial 911 or go directly to the nearest hospital emergency room. The message must give members an alternative contact number to reach the PCP or on-call provider with medical concerns or questions.

Language-Appropriate Messages
Non-English speaking members who call their PCP after hours should expect to get language-appropriate messages. In the event of an emergency, these messages should direct the member to dial 911 or proceed directly to the nearest hospital emergency room. In a nonemergency situation, members should receive instructions about how to contact the on-call provider. If an answering service is used, the service should know where to contact a telephone interpreter for the member. All calls taken by an answering service must be returned.

Network On-Call Providers
UniCare prefers that PCPs use network providers for on-call services. When that is not possible, the PCP must ensure that the covering on-call physician or other provider abides by the terms of the UniCare provider contract.

24/7 NurseLine Members may call the 24/7 NurseLine 24 hours a day, 7 days a week at 1-888-850-1108 to speak to a registered nurse. 24/7 NurseLine nurses provide health information regarding illness and options for accessing care, including emergency services.
Provider Roles and Responsibilities

Licenses and Certifications
Providers must maintain all licenses, certifications, permits, accreditations or other prerequisites required by UniCare and federal, state and local laws to provide medical services.

Provider Roles and Responsibilities

Eligibility Verification
All providers must verify member eligibility immediately before rendering services, supplies or equipment. Because eligibility may change monthly, a member eligible on the last day of the month may not be eligible on the first of the following month. UniCare is not responsible for charges incurred by ineligible persons. For details, refer to the How to Verify Member Eligibility section of this manual.

Provider Roles and Responsibilities

Collaboration
Providers share the responsibility of giving respectful care, working collaboratively with UniCare specialists, hospitals, ancillary providers and members and their families. Providers must permit members to participate actively in decisions regarding medical care, including, except as limited by law, their decision to refuse treatment. The provider facilitates interpreter services and provides information about the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program.

Provider Roles and Responsibilities

Continuity of Care
PCPs maintain frequent communication with specialists, hospitals and ancillary providers to ensure continuity of care. UniCare encourages providers to maintain open communication with members about appropriate treatment alternatives, regardless of the member’s benefit coverage limitations. PCPs are responsible for providing an ongoing source of primary care appropriate to the member’s needs. UniCare has established comprehensive mechanisms to ensure continued access to care for members when providers leave our health care program. Under certain circumstances, members may finish a course of treatment with the terminating provider. For more information, refer to the Provider Contract Termination section of this manual.

Provider Roles and Responsibilities

Medical Records Standards
Medical records must be maintained in a manner ensuring effective and confidential member care and quality review. At UniCare, we perform medical record reviews upon signing a provider contract. We then perform medical record reviews at least every three years to ensure that providers remain in compliance with these standards. Quality chart reviews are periodically conducted based on HEDIS and quality information. These reviews are designed to be educational and support quality activities. Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act. This act prohibits a health care provider from disclosing any individually identifiable information regarding a patient’s medical history, treatment, or behavioral and physical condition, without the patient’s or legal representative’s consent or specific legal authority. Records required through a legal instrument may be released without patient or patient representative consent. Providers must be familiar with the HIPAA security requirements and be in compliance.
Additional information on medical record storage, standards and security may be found in Chapter 18, beginning with the *Medical Record Documentation Standards* section.

**Provider Roles and Responsibilities**

**Mandatory Reporting of Child Abuse, Elder Abuse or Domestic Violence**

Providers must ensure that office staff is familiar with local reporting requirements and procedures regarding telephonic and written reporting of known or suspected cases of abuse. All health care providers must report immediately any actual or suspected child abuse, elder abuse or domestic violence to the local law enforcement agency by telephone. In addition, providers must submit a follow-up written report to the local law enforcement agency within the time frames required by law.

**Provider Roles and Responsibilities**

**Updating Provider Information**

Providers are required to inform UniCare of any material changes to their practice, including:

- Changes in:
- Professional business ownership
- Business address or the location where services are provided
- Nine-digit federal Tax Identification Number (TIN)
- Specialty
- Demographic data
- Services offered to children
- Languages spoken
- Legal or governmental action initiated against a health care provider. This type of action includes, but is not limited to, an action for professional negligence, for violation of the law, or against any license or accreditation. If successful, this action would impair the ability of the health care provider to carry out the duties and obligations under the Provider Agreement.
- Any other problems or situations that may impair the ability of the health care provider to carry out the duties and obligations under the Provider Agreement care review and grievance resolution procedures
- Notification that the provider is accepting new patients

Use the *Provider Change Form* to notify UniCare of changes. This form is available in the *Forms and Tools* section of the *Provider Resources* page of our website: [www.unicare.com](http://www.unicare.com). For directions on how to access the *Provider Resources* page of our website, please see *Chapter 1: How to Access Information, Forms and Tools on Our Website*.

**Provider Roles and Responsibilities**

**Oversight of Non-Physician Practitioners**

All providers using non-physician practitioners must provide supervision and oversight of these practitioners consistent with state and federal laws. The supervising physician and the non-physician practitioner must have written guidelines for adequate supervision. All supervising providers must follow state licensing and certification requirements.

Nonphysician practitioners include the following categories:

- Advanced registered nurse practitioners
- Certified nurse midwives
• Physician assistants

These nonphysician practitioners are licensed by the state and work under the supervision of a licensed physician, as mandated by state and federal regulations.

Provider Roles and Responsibilities

Open Clinical Dialogue and Affirmative Statement

Nothing within the Provider Agreement or this manual should be construed as encouraging providers to restrict medically necessary, covered services or to limit clinical dialog between providers and their patients. Providers may communicate freely with members regarding the available treatment options, including medications, regardless of benefit coverage limitations.

We will not prohibit or otherwise restrict practitioners acting within the lawful scope of practice from advising or advocating on behalf of their patients about their health status, medical care or treatment options.

Provider Roles and Responsibilities

Provider Contract Termination

A terminated provider who is actively treating members must continue treatment until the termination date. The termination date is the end of the 90-day period following written notice of termination, or according to a timeline determined by the contract.

After we receive a provider’s notice to terminate a contract, we notify members impacted by the termination. UniCare sends a letter to inform affected members about:

- The impending termination of the provider
- The member’s right to request continued access to care
- The Customer Care Center phone number to request PCP changes
- Referrals to the UM department for continued access to care consideration

Members under the care of specialists may submit requests for continued access to care, including after the transition period, by calling the Customer Care Center at 1-800-782-0095.

UniCare may terminate the Provider Agreement if we determine that the quality of care or services given by a health care provider is not satisfactory. We make this determination by reviewing member satisfaction surveys, utilization management data, member complaints or grievances, other complaints or lawsuits alleging professional negligence and quality of care indicators.

Provider Roles and Responsibilities

Termination of the Ancillary Provider/Patient Relationship

Under certain circumstances, an ancillary provider may terminate the professional relationship with a member, as provided for and in accordance with the provisions of this manual. However, ancillary providers may not terminate the relationship because of the member’s medical condition or the amount, type or cost of covered services required by the member.
Provider Roles and Responsibilities

Disenrollees
When a member disenrolls and requests a transfer to another health plan, providers are expected to work with the UniCare case managers responsible for helping the member make the transition. This transition must occur without disruption of any regimen of care that qualifies as a continuity of care condition. The case manager will coordinate with the member, the member’s providers and the case manager at the new health plan to ensure an orderly transition.

Provider Roles and Responsibilities

Provider Rights
Providers, acting within the lawful scope of practice, shall not be prohibited from advising a member or advocating on behalf of a member for any of the following:

- The member’s health status, medical care or treatment options, including any alternative, self-administered treatment
- Any information the member needs to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or non-treatment
- The member’s right to participate in decisions regarding his/her health care, including the right to refuse treatment and to express preferences about future treatment decisions
- To receive information on the grievances and appeals and state fair hearing procedures
- To have access to policies and procedures covering authorization of services
- To be notified of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested
- To challenge, on behalf of our members, the denial of coverage or payment for medical assistance
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable law based solely on that license or certification

UniCare’s provider selection policies and procedures do not discriminate against particular providers who serve high-risk populations or specialize in conditions requiring costly treatment.

Provider Roles and Responsibilities

Prohibited Activities
All providers are prohibited from:

- Billing eligible members for covered services
- Segregating members in any way from other persons receiving similar services, supplies or equipment
- Discriminating against UniCare members or Medicaid participants
CHAPTER 16: CLINICAL PRACTICE AND PREVENTIVE HEALTH CARE GUIDELINES

Customer Care Center phone: 1-800-782-0095
Customer Care Center fax: 1-888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Clinical Practice and Preventive Health Care Guidelines

Overview

At UniCare, we believe that providing quality health care should not be limited to the treatment of injury or illness. We are committed to helping providers and members become more proactive in the quest for better overall health. To accomplish this goal, we offer tools for providers to find the best, most cost-effective ways to:
- Provide member treatment
- Empower members through education
- Encourage member lifestyle changes, when possible

We want providers to have access to the most up-to-date clinical practice and preventive health care guidelines that are offered by nationally recognized health care organizations and based on extensive research. These guidelines include the latest standards for treating the most common and serious illnesses, such as diabetes and hypertension. These guidelines also include recommendations for preventive screenings, immunizations and member counseling based on age and gender.

Clinical Practice and Preventive Health Care Guidelines

Preventive Health Care Guidelines

UniCare considers preventive health guidelines to be an important component of health care. UniCare develops preventive health guidelines in accordance with recommendations made by nationally-recognized organizations such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetrics and Gynecology (ACOG) and the United States Preventive Services Task Force (USPSTF). These organizations make recommendations based on reasonable medical evidence. We review the guidelines annually for content accuracy, current primary sources, new technological advances and recent medical research. We make appropriate changes based on this review of the recommendations and/or preventive health mandates. We encourage providers to utilize these guidelines to improve the health of our members.

Locate the guidelines, educational materials and health management programs in the Quality Improvement Program section of the Provider Resources page on our website at www.unicare.com. Select Preventive Health Care Guidelines. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website. The preventive health care guidelines available include the following:
- Medical Policy Preventive Health Guidelines
- United States Health and Human Services Administration for Children and Families Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- In the Member Preventive Health Care Guidelines section: Preventive Health Care Guidelines
The UniCare website offers the most up-to-date clinical resources for preventive screenings, immunizations and counseling for our members. If you do not have Internet access, request a hard copy of the preventive health care guidelines by calling our Customer Care Center at 1-800-782-0095.

**Please note:** Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Actual member benefits and eligibility are determined in accordance with the requirements set forth by the state and as set forth in the member’s Evidence of Coverage and Member Handbook.

**Clinical Practice and Preventive Health Care Guidelines**

**Clinical Practice Guidelines**

UniCare considers clinical practice guidelines to be an important component of health care. UniCare adopts nationally-recognized clinical practice guidelines and encourages physicians to utilize these guidelines to improve the health of our members. Several national organizations produce guidelines for asthma, diabetes, hypertension and other conditions. The guidelines, which UniCare uses for quality and disease management programs, are based on reasonable medical evidence. We review the guidelines at least every two years, or when changes are made to national guidelines, for content accuracy, current primary sources, new technological advances and recent medical research.

Providers may access the up-to-date listing of the clinical practice guidelines in the *Quality Improvement Program* section of the *Provider Resources* page on the UniCare website at www.unicare.com. Select *Clinical Practice Guidelines* and click any link in the table of contents to display that topic. For directions on how to access the *Provider Resources* page of our website, please see *Chapter 1: How to Access Information, Forms and Tools on Our Website*.

The UniCare website offers the most up-to-date clinical resources and guidelines. If you do not have Internet access, request a hard copy of the clinical practice guidelines by calling our Customer Care Center at 1-800-782-0095.

**Please note:** Our recommendation of these guidelines is not an authorization, certification, explanation of benefits, or a contract. Actual member benefits and eligibility for services are determined in accordance with the requirements set forth by the state and as set forth in the member’s Evidence of Coverage and Member Handbook.
CHAPTER 17: CASE MANAGEMENT

Case Management phone: 1-304-347-2475
Case Management email: wvcmreferrals@anthem.com
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Case Management Overview
Case Management is a process that emphasizes teamwork to assess, develop, implement, coordinate and monitor treatment plans in order to optimize our members’ health care benefits and promote quality outcomes.

UniCare’s Case Management program, provided at no cost to our members, offers expert assistance in the coordination of complex health care. The Case Manager, through interaction with the member, the member’s representative and/or providers, collects data and analyzes information about actual and potential care needs for the purpose of developing a treatment plan. Cases referred to the Case Management department may be identified by disease or condition, dollars spent or high utilization of services.

Please note: The UniCare Case Management department is sensitive to the impact cultural diversity has on our members and their interaction within the health care system. We encourage providers to become familiar with our cultural and linguistic training materials, available in the Health Education section on the Provider Resources page at www.unicare.com. Select the Cultural Competency Training and Caring for Diverse Populations documents. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Case Management Role of the Case Manager
The case manager’s role is to assess the member’s health care status, develop a health care plan and:

- Facilitate communication and coordination within the health care team.
- Facilitate communication with the member and his or her representative in the decision-making process.
- Educate the providers on the health care team and the member about case management, community resources, benefits, cost factors and all related topics to assist in making informed decisions.
- Encourage appropriate use of medical facilities and services, with the goal of improving quality of care and maintaining cost-effectiveness on a case-by-case basis.

The Case Management department includes experienced and credentialed registered nurses, some of whom are certified case managers. The team also includes social workers, who add valuable skills that allow us to address our members’ medical needs, as well as psychological, social and financial issues.

Case Management Provider Responsibilities
PCPs have the responsibility of participating in case management, sharing information and facilitating the process by:

- Referring members who could benefit from case management.
• Sharing information as soon as the PCP identifies complex health care needs.
• Collaborating with Case Management staff on an ongoing basis.
• Referring members to specialists, as required.
• Monitoring and updating the care plan to promote health care goals.
• Notifying Case Management if members are referred to services provided by the state or some other institution not covered by the UniCare agreement.
• Coordinating county- or state-linked services such as public health, behavioral health, schools and waiver programs. The provider may call Case Management for additional assistance.

Case Management

Case Management Procedure
When a member has been identified as having a condition that may require case management, the case manager contacts the member and the referring provider (if the referral was from a provider) for an initial assessment. Then, with the involvement of the member, the member’s representative and the provider, the case manager develops an individualized care plan. This plan may involve coordinating services with public and behavioral health departments, schools, and other community health resources.

The case manager periodically re-assesses the care plan to monitor the following:
• Progress toward goals
• Necessary revisions
• New issues to be addressed to ensure the member receives the support necessary to achieve care plan goals

After goals are met or case management can no longer impact the case, the case manager closes the case.

Case Management

Potential Referrals
Providers, nurses, social workers and members or their representatives may request Case Management services. Examples of cases appropriate for referral include:
• Children or adults with special health care needs requiring coordination of care
• HIV/AIDS
• Chronic illness such as asthma, diabetes and heart failure
• Complex- or multiple-care needs such as multiple trauma or cancer
• Frequent hospitalizations or emergency room utilization
• Hemophilia, sickle cell anemia, cystic fibrosis or cerebral palsy
• High-risk or teen pregnancies
• Potential transplants
• Preterm births
Case Management

Referral Process
To request case management services, providers, nurses, social workers, and members or their representatives may call 1-304-347-2475 or send a Care Management Referral Form by email to wvcmediareferrals@anthem.com. A case manager will respond to a request within three business days. Download the Care Management Referral Form from the Forms and Tools section of the Provider Resources page at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Disease Management

Overview
Our Disease Management Centralized Care Unit (DMCCU) is based on a system of coordinated care management interventions and communications designed to assist physicians and other health care professionals manage members with chronic conditions. DMCCU services include a holistic, member-centric care management approach that allows care managers to focus on multiple needs of members. Our disease management programs include:

- Asthma
- Chronic obstructive disorder (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Substance use disorder
- Bipolar disorder
- Major depressive disorder
- Schizophrenia

In addition to our 11, condition-specific disease management programs, our member-centric, holistic approach also allows us to assist members with managing their weight.

DMCCU also offers weight management and smoking cessation services.

Disease Management

Program Features
- Proactive identification process
- Evidence-based clinical practice guidelines from recognized sources
- Collaborative practice models that include the physician and support providers in treatment planning
- Continuous self-management education
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with providers regarding patient status

Disease management clinical practice guidelines are located at www.unicare.com. Simply access the page and log into the secure site by entering your User Name and Password. Please select the Clinical
Policy & Guidelines link on the top navigation menu. A copy of the guidelines can be printed from the website, or you can call Provider Services at 1-888-483-0793 to receive copy.

Disease Management
Who is Eligible?
All members with the listed conditions are eligible. We identify them through:
- Continuous case finding welcome calls
- Claims mining
- Referrals

As a valued provider, we welcome your referrals of patients who can benefit from additional education and care management support. Our care managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk stratified based on the severity of their disease. They are provided with continuous education on self-management concepts, which include primary prevention, behavior modification and compliance/surveillance, as well as case/care management for high-risk members. Program evaluation, outcome measurement and process improvement are built into all the programs. Providers are given telephonic and/or written updates regarding patient status and progress.

Disease Management
Centralized Care Unit Provider Rights and Responsibilities
You have the right to:
- Have information about UniCare, including:
  - Provided program and services
  - Our staff
  - Our staff’s qualifications
  - Any contractual relationships
- Decline to participate in or work with any of our programs and services for your patients
- Be informed of how we coordinate our interventions with your patient’s treatment plans
- Know how to contact the person who manages and communicates with your patients
- Be supported by our organization when interacting with patients to make decisions about their health care
- Receive courteous and respectful treatment from our staff
- Communicate complaints about DMCCU as outlined in the UniCare provider complaint and Grievance procedure

Disease Management
Hours of Operation
Our DMCCU case managers are licensed nurses. They are available:
- 8:30 a.m. to 5:30 p.m. local time
Confidential voicemail is available 24 hours a day. The Nurse Helpline is available for our member 24 hours a day, 7 days a week.

Contact Information
You can call a DMCCU team member at 1-888-830-4300. DMCCU program content is located www.unicare.com. Printed copies are available upon request. Members can obtain information about the DMCCU program by visiting www.unicare.com or calling 1-888-830-4300.
CHAPTER 18: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Customer Care Center phone: 1-800-782-0095
Customer Care Center fax: 1-888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Quality Assessment and Performance Improvement

Overview
UniCare’s long-standing goal has been continuous, measurable improvement in our delivery of quality health care. Following federal and state guidelines, we have a Quality Improvement (QI) program in place to objectively and systematically monitor and evaluate the quality, safety and appropriateness of medical care and service offered by the health network. The QI program also serves to identify and act on opportunities for improvement. Continuous improvement is our ongoing effort to be better at what we do.

The QI program includes focused studies that measure quality of care in specific clinical and service areas. All providers are expected to participate in these studies as part of our mutual goal of providing responsive and cost-effective health care that improves our members’ lives.

We also participate in national evaluations designed to gauge our performance and the performance of providers. The National Committee for Quality Assurance (NCQA) provides an important measure of performance in its annual reporting of the Healthcare Effectiveness Data and Information Set (HEDIS) scores to health care plans throughout the country. This professional evaluation serves as a yearly report card and is a tool used by more than 90% of America’s health care plans to rate performance across a wide spectrum of care and service areas, including:

- Access and service
- Qualified providers
- Staying healthy
- Getting better
- Living with illness

The HEDIS results may be used by potential members to make comparisons before choosing a health care plan. UniCare uses the HEDIS data to identify areas for improvement and shares the results with providers. We submit the results of the HEDIS assessment and our own quality studies annually to the West Virginia Bureau for Medical Services (BMS).

And finally, we are committed to working collaboratively with network providers and hospitals to identify preventable adverse events (PAE) that are measurable and preventable as a means of improving the quality of patient care.

Quality Assessment and Performance Improvement

Quality Improvement Program
The QI program focuses on developing and implementing standards for clinical care and service, measuring conformity to those standards, and taking action to improve performance. The scope of the QI program includes, but is not limited to, the monitoring and evaluation of:

- Care and service provided in all health delivery settings
- Chronic disease management and prevention
- Maternity management programs
- Coordination of medical care
- Coordination of Medical and BH
- Community health
• Facility site review
• Service quality
• Case management of members with complex health conditions
• Medical record review
• Provider/member satisfaction
• Utilization management

UniCare develops an annual work plan of quality improvement activities based on the results of the previous year’s QI program evaluation. Then, we review, evaluate and revise the QI program’s effectiveness. The evaluation is a written description of UniCare’s ability to implement the QI program, meet program objectives, and develop and implement plans to improve the quality of care and service to our members. Providers support the activities of the QI program by:

• Participating in the facility and medical record audit process.
• Providing access to medical records for quality improvement projects and studies.
• Responding in a timely manner to requests for written information and documentation if a quality of care or grievance issue has been filed.
• Using preventive health and clinical practice guidelines in member care.
• Completing corrective action plans, when applicable.

Quality Assessment and Performance Improvement

Healthcare Effectiveness Data and Information Set

HEDIS is a national evaluation and a core set of performance measurements gauging the effectiveness of UniCare and the network providers in delivering quality care. We are ready to help when the providers and their office staff need training to participate in required HEDIS evaluations. Providers can request consultations and training in the following areas:

• Information about the year’s selected HEDIS studies
• How data for those measures will be collected
• Codes associated with each measure
• Tips for smooth coordination of medical record data collection

UniCare’s QI staff will contact the provider’s office when we need to review or copy any medical records required for HEDIS or QI studies. UniCare requests that records be returned within five business days to allow time to abstract the records and request additional information from other providers, if needed. Office staff must provide access to medical records for review and copy, if necessary.

Quality Assessment and Performance Improvement

Practitioner/Provider Performance Data
Practitioners and providers must allow UniCare to use performance data in cooperation with our quality improvement program and activities.

Practitioner/provider performance data means compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual health care practitioner such as a physician, or, a healthcare organization such as a hospital. Common examples of performance data include the HEDIS quality of care measures maintained by the NCQA and the comprehensive set of measures maintained by the National Quality Forum (NQF). Practitioner/provider performance data may be used for multiple plan programs and initiatives including but not limited to:

• Reward programs — pay for performance (P4P), pay for value (PFV) and other results-based reimbursement programs that tie provider or facility reimbursement to performance against a defined
set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules and bundled payment arrangements.

- Recognition programs — programs designed to transparently identify high-value providers and facilities and make that information available to consumers, employers, peer practitioners and other health care stakeholders.

**Quality Assessment and Performance Improvement**

**Quality Management**

Annually, and in accordance with NCQA standards, UniCare analyzes relevant utilization data against established thresholds for each health plan to detect current utilization levels. If our findings fall outside specified target ranges and indicate potential under-utilization or over-utilization, further analysis will occur based on the recommendation of UniCare’s Quality Management Committee (QMC). The follow-up analysis may include gathering the following data from specific provider and practice sites:

- Case management services needed by members
- Claims payments for covered services
- Coordination with other providers and agencies
- Focus studies
- Investigation and resolution of member and provider complaints and appeals within established time frames
- Retrospective reviews of services provided without authorization

**Quality Assessment and Performance Improvement**

**Best Practice Methods**

Best practice methods are UniCare’s most up-to-date compilation of effective strategies for quality health care delivery. We share best practice methods during site visits to provider offices. The Network Management teams offer UniCare policies, procedures and educational toolkits to help guide improvements. Toolkits may include examples of best practices from other offices, including:

- Resources for improving compliance with preventive health services
- Clinical practice guidelines
- Care for members with special or chronic care needs

**Quality Assessment and Performance Improvement**

**Member Satisfaction Surveys**

Member satisfaction with our health plan services is measured every year by the NCQA. The NCQA conducts a member satisfaction survey called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The survey is designed to measure member satisfaction with UniCare services, including:

- Access to care
- Physician care and communication with members
- UniCare customer service

Each year, UniCare shares the results of the CAHPS survey with providers in the UniCare network. Providers should review and share the results with office staff and incorporate appropriate changes to their offices in an effort to improve scores.
Quality Assessment and Performance Improvement

Provider Satisfaction Surveys
UniCare may conduct provider surveys to monitor and measure provider satisfaction with UniCare’s services and to identify areas for improvement. Provider participation in these surveys is highly encouraged and your feedback is very important. We inform providers of the results and plans for improvement through provider bulletins, newsletters, meetings or training sessions.

Quality Assessment and Performance Improvement

Facility Site and Medical Record Reviews
UniCare conducts facility site and medical record reviews to determine provider:

- Compliance with standards for providing and documenting health care.
- Compliance with standards for storing medical records.
- Compliance with processes that maintain safety standards and practices.
- Involvement in the continuity and coordination of member care.

Please note: BMS and UniCare have the right to enter into the premises of providers to inspect, monitor, audit or otherwise evaluate the work performed. We perform all inspections and evaluations in such a manner as to not unduly delay work, in accordance with the provider contract.

Quality Assessment and Performance Improvement

Medical Record Documentation Standards
UniCare requires providers to maintain medical records in a manner that is current, organized, and permits effective and confidential member care and quality review. We perform medical record reviews of all providers upon signing of a contract and, at a minimum, every three years thereafter to ensure that network providers are in compliance with these standards.

Providers must agree to maintain the confidentiality of member information and other information contained in a member’s medical record according to HIPAA standards. The Confidentiality of Medical Information Act prohibits a provider of health care from disclosing any individually-identifiable information regarding a patient’s medical history, mental and physical condition, or treatment without the patient’s or legal representative’s consent or specific legal authority. The provider will release such information only as permitted by applicable federal, state and local laws. Any information released must be necessary to other providers and the health plan, related to treatment, payment, or health care operations. In addition, information must be released upon the member’s signed and written consent.

Quality Assessment and Performance Improvement

Medical Record Security
Medical records must be secure and inaccessible to unauthorized persons to prevent loss, tampering, disclosure of information, alteration or destruction of the records. Information must be accessible only to authorized personnel within the provider’s office, UniCare, BMS or to persons authorized through a legal instrument. Records must be made available to UniCare for purposes of quality review, HEDIS and other studies. Office personnel will ensure that individual patient conditions or information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas.
Quality Assessment and Performance Improvement

Medical Record Storage and Maintenance

Active medical records must be secured and inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed and organized, permitting effective patient care and quality review while maintaining confidentiality. Inactive records are to remain accessible for a period of time that meets state and federal guidelines.

Electronic record-keeping system procedures must be in place to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures and maintain upkeep of computer systems. Security systems must be in place to provide back-up storage and file recovery, to provide a mechanism to copy documents and to ensure that record input is unalterable.

Quality Assessment and Performance Improvement

Availability of Medical Records

The medical record system must allow for prompt retrieval of each record when the member comes in for a visit. Providers must maintain members’ medical records in a detailed and comprehensive manner that accomplishes the following:

- Conforms to good professional medical practice
- Facilitates an accurate system for follow-up treatment
- Permits effective, professional medical review and medical audit processes

Medical records must be legible, signed and dated, and maintained for at least seven years as required by state and federal regulations.

Providers must supply a copy of a member’s medical record upon reasonable request by the member at no charge. The provider must facilitate the transfer of the member’s medical record to another provider at the member’s request. Access to medical records and confidentiality must be provided in accordance with the standards mandated in HIPAA, as well as all other state and federal requirements.

Providers must permit UniCare and representatives of BMS to review members’ medical records for the purposes of monitoring the provider’s compliance with the medical record standards, capturing information for clinical studies, monitoring quality, or any other reason. BMS encourages providers to use technology, such as health information exchanges, to transmit and store medical record data.

Quality Assessment and Performance Improvement

Medical Record Requirements

At a minimum, every medical record must include:

- The patient’s name or identification (ID) number on each page in the record
- Personal biographical data, including home address, employer, emergency contact name and telephone number, home and work telephone numbers, and marital status
- Entries dated with the month, day and year
- Entries containing the author’s identification and title. For example, handwritten signature, unique electronic identifier or initials
- Identification of all providers participating in the member’s care
- Information on the services furnished by all providers
- List of problems, including significant illnesses, medical conditions and psychological conditions
- Presenting complaints, diagnoses, and treatment plans, including the services to be delivered
- Physical findings relevant to the visit, including vital signs, normal and abnormal findings, and appropriate subjective and objective information
• Information on allergies and adverse reactions, or a notation that the patient has no known allergies or history of adverse reactions
• Information on advance directives
• Past medical history, including serious accidents, operations and illnesses. In addition:
  o For patients 14 years old and older, the record must include information about substance abuse
  o For children and adolescents, the record must include past medical history as relates to prenatal care, birth, operations, and childhood illnesses
• Notations concerning the use of cigarettes, alcohol and substance abuse for patients 14 years and older, including anticipatory guidance and health education
• Physical examinations, treatment required, and possible risk factors relevant to the treatment
• Prescribed medications, including dosages and dates of initial or refill prescriptions
• Information about the individuals who have been instructed in assisting the patient
• Medical records must be legible, dated, and signed by the provider, physician assistant, nurse practitioner or nurse midwife providing patient care
• Up-to-date immunization records for children, or an appropriate history for adults
• Documentation of attempts to provide immunizations. If the member refuses immunization, document proof of voluntary refusal of the immunization in the form of a signed statement by the member or guardian
• Evidence of preventive screening and services in accordance with UniCare’s preventive health practice guidelines
• Documentation of referrals, consultations, diagnostic test results, and inpatient records. Evidence of the provider’s review may include the provider’s initials or signature and notation in the patient’s medical record. The provider may indicate review and patient contact, follow-up treatment, instructions, return office visits, referrals and other patient information
• Notations of appointment cancellations or No Shows and the attempts to contact the member to reschedule
• No indication or implication that the patient was placed at inappropriate risk by a diagnostic test or therapeutic procedure
• Documentation on whether an interpreter was used in any visit (initial or follow-up)

Quality Assessment and Performance Improvement

Missrouted Protected Health Information

Providers and facilities are required to review all member information received from UniCare to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice (RA). Providers and facilities are required to destroy immediately any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please contact the Customer Care Center at 1-800-782-0095.

Quality Assessment and Performance Improvement

Advance Directives

Recognizing a person’s right to dignity and privacy, our members have the right to execute an advance directive, also known as a living will, to identify their wishes concerning health care services should they become incapacitated. Providers may be asked to assist members in procuring and completing the necessary forms. For more information, go to the Policies, Manuals and Guidelines section of the Provider Resources page at www.unicare.com. Select the Advance Directives document. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.
Ready access to Advance Directive documents is recommended in the event a member requests this information. Advance Directive documents should be properly noted in the member’s medical record, when applicable.

Quality Assessment and Performance Improvement

Medical Record Review Process

UniCare’s QI team will call the provider’s office to schedule a medical record review on a date and time that will occur within 30 days. On the day of the review, the QI staff will:
1. Request the number and type of medical records required.
2. Review the appropriate number and type of medical records per provider.
3. Complete the medical record review.
4. Meet with the provider or office manager to review and discuss the results of the medical record review.
5. Provide a copy of the medical record review results to the office manager or provider, or send a final copy within 10 days of the review.
6. Schedule follow-up reviews for any corrective actions identified.

Providers must attain a score of 80% or greater to pass the medical record review.

Quality Assessment and Performance Improvement

Facility Site Review Process

An initial facility site review and inspection is required for all PCP sites, OB/GYNs and high-volume specialists participating in the UniCare program

A facility site review inspection consists of 13 elements, including the following:
1. Accessibility
2. Appearance
3. Safety and infectious waste disposal
4. Office policies
5. Provider availability
6. Treatment areas
7. Patient services
8. Process of documentation
9. Personnel
10. Medications, including emergency supplies
11. Referral process
12. Medical records elements and organization
13. Appointment accessibility

A facility site review is required if the site has not been previously reviewed and accepted as part of UniCare’s credentialing process. In addition:
- Facility site reviews are required as part of the initial credentialing process for new providers, as well as every three years. In addition, if a provider reaches a threshold of three complaints in a rolling twelve months, a facility site review will be conducted.
- OB/GYN specialty sites and high-volume specialists participating in the UniCare program and not serving as PCPs must undergo an initial site inspection.
- Practitioners must notify UniCare when relocating to a new site or when adding a new site. If a review has not been previously performed at the new site, UniCare will perform a facility site review prior to members being seen.
A UniCare QI department associate will call the provider’s office to schedule an appointment date and time before the facility site review due date. The associate will fax or mail a confirmation letter with an explanation of the audit process and required documentation. During the facility site review, the QI associate will:
1. Lead a prereview conference with the provider or office manager to review and discuss the facility review process and answer any questions.
2. Conduct the facility site review.
3. Complete the facility site review.
4. Develop a corrective action plan, if applicable.

After the facility site review is completed, UniCare’s QI associate will meet with the provider or office manager to:
1. Review and discuss the results of the facility site review and explain any required corrective actions.
2. Provide a copy of the facility site review results and the corrective action plan to the office manager or provider. Or, the QI associate may send a final copy within 10 days of the review.
3. Educate the provider and office staff about UniCare standards and policies.
4. Schedule a follow-up review for any corrective actions identified.

Providers must attain a score of 80% or greater with no deficiencies in critical elements to pass the facility site review.

**Critical Elements:** Critical elements include making sure sharps containers are present, autoclave spore testing*, universal precautions, medication storage, and availability of emergency equipment*. Full compliance with critical elements must be attained.

*When applicable.

**Quality Assessment and Performance Improvement**

**Facility Site Review: Corrective Actions**

If the facility site review results in a nonpassing score, UniCare will notify providers immediately of the nonpassing score, all cited deficiencies and corrective action requirements. The provider office will develop and submit a corrective action plan. UniCare will conduct follow-up visits every six months until the site complies with UniCare standards.

The provider and office staff will:
- Submit a corrective action plan with verification for all critical elements and/or other survey deficiencies requiring immediate correction within 10 business days of the survey. Critical element deficiencies will be re-evaluated within 30 days of the site visit. Additional time may be granted, if necessary.
- Submit a corrective action plan for all other deficiencies within 30 days of the survey.

If deficiencies (other than critical) are not closed within 60 days of the date of the written corrective action plan request, or if the provider is otherwise uncooperative with resolving outstanding issues with the facility site review, the provider will be considered noncompliant.
Quality Assessment and Performance Improvement

Preventable Adverse Events

The breadth and complexity of today’s health care system means there are inherent risks, many of which can be neither predicted nor prevented. However, when there are preventable adverse events, they should be tracked and reduced, with the ultimate goal of elimination.

Providers and health care systems, as advocates for our members, are responsible for the continuous monitoring, implementation and enforcement of applicable health care standards. Focusing on patient safety, we work collaboratively with network providers and hospitals to identify preventable adverse events and to implement appropriate strategies and technologies to avoid preventable adverse events. Our goal is to enhance the quality of care received not only by our members, but by all patients receiving care in these facilities.

Prevention of adverse events may require the disclosure of PHI. HIPAA specifies that PHI may be disclosed for the purpose of health care operations in relation to quality assessment and improvement activities. The information shared with us is legally protected through the peer review process and will be maintained in a strictly confidential manner. If you receive a request for medical records, please provide the records within 10 days of the date of the request.

We will continue to monitor activities related to the list of adverse events from federal, state and private payers, including Never Events.

Never Events: As defined by the National Quality Forum (NQF), Never Events are adverse events that are serious, but largely preventable, and of concern to both the public and health care providers.

Preventable adverse events should not occur. When they do, we firmly support the concept that a health plan and its members should not pay for resultant services.

Section 2702(a) of the Affordable Care Act prohibits Federal financial participation (FFP) payments to states for any amounts expended for providing medical assistance for provider preventable conditions (PPCs), including health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs). PPCs are hospital-acquired conditions not present on hospital admission, the wrong procedure performed on a patient, and procedures performed on a wrong patient or body part.

The MCO may not make payments for PPCs as defined by the federal regulations and BMS policy in accordance with 42 CFR 438.6. The MCO will track PPC data and make it available to BMS upon request.

Please note: Medicaid is prohibited from paying for certain health care acquired conditions (HCAC). This applies to all hospitals.

Quality Assessment and Performance Improvement

Practitioner / Provider Performance Data

Practitioner/provider performance data means compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual health care practitioner, such as a physician, or a health care organization, such as a hospital.

Common examples of performance data would include the HEDIS quality of care measures maintained by the National Committee for Quality Assurance (NCQA) and the comprehensive set of measures maintained by the National Quality Forum (NQF).
Practitioner/provider performance data may be used for multiple plan programs and initiatives, including but not limited to:

- **Reward programs** — pay for performance (P4P), pay for value (PFV) and other results-based reimbursement programs that tie provider or facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules and bundled payment arrangements.

- **Recognition programs** — programs designed to transparently identify high-value providers and facilities and make that information available to consumers, employers, peer practitioners and other health care stakeholders.
CHAPTER 19: ENROLLMENT AND MARKETING RULES

Customer Care Center phone: 1-800-782-0095
Customer Care Center fax: 1-888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Enrollment and Marketing Rules

Overview
The delivery of quality health care poses numerous challenges, not the least of which is the commitment shared by UniCare and providers to protect our members. We want our members to make the best health care decisions possible. And when members ask for our assistance, we want to provide that assistance so they make those decisions without undue influence.

UniCare recognizes that providers occupy a unique, trusted and respected part of people’s lives. Given the complexity of modern-day health care and the inherent difficulties communicating with some of the populations we serve, there are potential pitfalls when UniCare or providers try to assist in the decision-making process. Sometimes, even though the intent is to help make our members’ lives better, we may overstep.

For that reason, we are committed to following the enrollment and marketing guidelines created by the West Virginia Bureau for Medical Services (BMS), and to honoring the rules for all state health care programs.

Enrollment and Marketing Rules

Marketing Policies
Providers serving members enrolled in Medicaid Managed Care are required to comply with the federal marketing regulations in 42 CFR 438.104, as well as marketing polices set forth by BMS in its contract with MCOs. Under these regulations both MCOs and providers are prohibited from the following activities:

- Engaging in direct marketing to enrollees that is designed to increase enrollment in a particular MCO
- Distributing marketing materials written above the 6th grade reading level, unless approved by the department
- Distributing gifts from MCOs directly to the MCO’s potential members or currently enrolled members
- Distributing directly or through any agent or independent contractor marketing materials that contain false or misleading information
- Making any assertion or statement (orally or in writing) that the any MCO is endorsed by CMS, a federal or state government agency, or similar entity
- Using terms that would influence, mislead, or cause potential members to contact an MCO, rather than the enrollment broker, for enrollment
- Making any written or oral statements containing material misrepresentations of fact or law relating to an MCO’s plan or the Medicaid program, services, or benefits
- Making potential member gifts conditional based on enrollment with the MCO
- Posting MCO-specific, non-health related materials or banners in provider offices
- Conducting potential member orientation in common areas of providers’ offices
- Soliciting enrollment or disenrollment in any MCO, or distributing MCO-specific materials at a marketing activity (This does not apply to health fairs where providers do immunizations, blood
• Discriminating against a member or potential member because of race, age, color, religion, natural origin, ancestry, marital status, sexual orientation, physical or mental disability, health status or existing need for medical care, with the following exception: certain gifts and services may be made available to members with certain diagnoses
• Assisting with Medicaid MCO enrollment form
• Making false, misleading or inaccurate statements relating to services or benefits of the MCO or Medicaid program, or relating to the providers or potential providers contracting with the MCO
• Using social media as a means to:
  o Post or send protected private information
  o Advertise via direct communication with potential members
  o Directly respond to any members for anything other than a general response (such as MCO phone number or website links)
  o Partake in individual communication
  o Request or add followers or friends
  o Tag individuals

Enrollment and Marketing Rules

Enrollment Process
BMS determines the eligibility and enrollment for UniCare members. The enrollment process is as follows:

• The enrollment broker presents managed health care plan options to individuals and families eligible for UniCare.
• Eligible members enroll in the plan of their choice and select a PCP; or, UniCare assigns a PCP to the member. The head-of-household completes applications and makes selections on behalf of children eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.
• The enrollment broker informs UniCare of new member enrollment. After enrollment, the broker updates UniCare about any changes in member eligibility, status or contact information, such as change of address.
• UniCare notifies providers about newly-assigned members through monthly enrollment rosters. Providers also have access to these rosters by logging into our secure provider website at www.unicare.com.
• UniCare sends each new member a New Member Kit within one week of receiving the BMS monthly enrollment roster. This kit includes a Member Handbook, a letter and the Evidence of Coverage.
• UniCare sends the member ID card within five days of receiving the monthly enrollment roster. The ID card includes the PCP contact information.

Please note: BMS will re-enroll any member automatically who loses UniCare eligibility but becomes eligible again within one year or less. Members will return to the same health care plan and PCP they had prior to disenrollment, if available. Members also may choose to switch plans at the time of re-enrollment.

Please note: To support the member enrollment process, PCPs are encouraged to maintain open panels. The state requires that 80% of UniCare PCPs have open panels; your open panel will assist us in meeting this requirement.
Open panels: The commitment by UniCare-contracted providers to accept new UniCare members.

Enrollment and Marketing Rules

Enrolling Newborns
Initially, a newborn is covered under the mother’s plan. Newborn delivery notification is required using the Newborn Enrollment Notification Report. Complete the entire form and include the newborn’s name, date of birth and other pertinent information. Fax the completed form to 1-855-402-6983. To prevent delay in UniCare coverage for newborns, submit the Newborn Enrollment Notification Report to notify UniCare about delivery within three days of the delivery.

Request that your patients take these steps as soon as their babies are born:
- Immediately contact BMS or their social worker to request the required paperwork
- Fill out and return the required paperwork to the state to enroll their newborn in Medicaid

The Newborn Enrollment Notification Report is located in the Forms and Tools section of the Provider Resources page at www.unicare.com.

Please note: To admit a baby for health reasons beyond a normal nursery admission, complete the Request for Preservice Review form in addition to the Newborn Enrollment Notification Report. The Request for Preservice Review form is located in the Prior Authorization Toolkit (also referred to as the UM Toolkit) on the Provider Resources page at www.unicare.com. Select UM Toolkit and select Request for Preservice Review.

For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.
CHAPTER 20: FRAUD, ABUSE AND WASTE

Customer Care Center phone: 1-800-782-0095
Customer Care Center fax: 1-888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

First Line of Defense Against Fraud

We are committed to protecting the integrity of our health care program and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

- **Fraud**: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person. The attempt itself is fraud regardless of whether or not it is successful.

- **Waste**: Includes overusing services or other practices which, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions but rather occurs when resources are misused.

- **Abuse**: When health care providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes or services that are not medically necessary.

To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Our company may not accept responsibility for the costs incurred by providers supplying services to a person who is not a member even if that person presents a current member identification card. Providers should take measures to ensure the cardholder is the person named on the card.

Every member identification card lists the following:

- Effective date of membership
- Member date of birth
- Subscriber number (identification number)
- Carrier and group number (RXGRP number) for an injectable
- PCP name, telephone number and address
- Copays for office visits, emergency room visits and pharmacy services (if applicable)
- Behavioral health benefit
- Vision service plan telephone number and dental service plan telephone number
- Member Services and NurseLine telephone numbers

For samples of the member ID card, refer to the “Member Identification Cards” section. Presentation of a member identification card does not guarantee eligibility; providers should verify a member’s status by inquiring online or via telephone. Online support is available for provider inquiries on the website and telephonic verification may be obtained through the automated Customer Care Center at 1-800-782-0095.

Providers should encourage members to protect their identification cards as they would a credit card, to carry their health benefits card at all times, and report any lost or stolen cards to our company as soon as possible. Understanding the various opportunities for fraud and working with members to protect
their health benefit ID card can help prevent fraudulent activities. If you or a patient suspect ID theft, call our Customer Care Center at 1-800-782-0095. Providers should instruct their patients who suspect identification theft to watch the EOB for any errors and then contact member services if something is incorrect.

**Reporting Fraud, Waste and Abuse**

If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting our website and completing the *Report Waste, Fraud and Abuse* form, [www.unicare.com > Provider Resources > Forms and Tools.](http://www.unicare.com)
- Calling Provider Services.
- Calling our Special Investigations Unit fraud hotline at 1-855-315-8927.

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

**Examples of Provider Fraud, Waste and Abuse:**

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling — multiple procedure codes billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding — a provider billing a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened
Examples of Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the member’s identification card
- Obtaining controlled substances from multiple providers
- Relocating to out-of-service plan area
- Using someone else’s identification card

When reporting concerns involving a member include:

- The member’s name
- The member’s date of birth, Social Security Number or case number if you have it
- The city where the member resides
- Specific details describing the fraud, waste or abuse

Investigation Process

We investigate all reports of fraud, abuse and waste for all services provided under the contract, including those that subcontracted to outside entities. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste or abuse, which may include but is not limited to:

- **Written warning and/or education**: We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries, or may advise of further action.
- **Medical record audit**: We review medical records to substantiate allegations or validate claims submissions.
- **Special claims review**: A certified professional coder or investigator evaluates claims and places payment or system edits on file. This type of review prevents automatic claim payment in specific situations.
- **Recoveries**: We recover overpayments directly from the provider within 30 days. Failure of the provider to return the overpayment after 30 days may result in reduced payment of future claims or further legal action.

Acting on Investigative Findings

We refer all criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

If a provider appears to have committed fraud, waste, or abuse the provider:

- Will be referred to the Special Investigations Unit
- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our health care plan with state approval.
Relevant Legislation

**False Claims Act**

We are committed to complying with all applicable federal and state laws, including the federal False Claims Act (FCA). The FCA is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim. The FCA also contains *qui tam* or whistleblower provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under *qui tam* provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

**HIPAA**

The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud and simplifies the administration of health insurance.

- Our company recognizes its responsibility under HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us; however, privacy regulations allow the transfer or sharing of member information. Our company may request information to conduct business and make decisions about care such as a member’s medical record, authorization determinations or payment appeal resolutions. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.

- Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at our company and verify the fax was received.

- Email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing member information (e.g., Excel spreadsheets with claim information; such information should be mailed or faxed.)

- Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked “confidential” and addressed to a specific individual, P.O. Box or department at our company.

- Our company voicemail system is secure and password-protected. When leaving messages for any of our associates, leave only the minimum amount of member information required to accomplish the intended purpose.

- When contacting us, please be prepared to verify the provider’s name, address and tax identification number (TIN) or member’s provider number.

**Employee Education about the False Claims Act**

As a requirement of the Deficit Reduction Act of 2005, contracted providers who receive Medicaid payments of at least $5 million (cumulative from all sources), must comply with the following:

- Establish written policies for all employees, managers, officers, contractors, subcontractors and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or
criminal penalties for false claims, and whistleblower protections under such laws, as described in section 1902(a)(68)(A).
• Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, waste and abuse. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, waste and abuse.
CHAPTER 21: MEMBER RIGHTS AND RESPONSIBILITIES

Customer Care Center phone: 1-800-782-0095
Customer Care Center fax: 1-800-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Member Rights and Responsibilities

Overview

Members should be clearly informed about their rights and responsibilities so they can make the best health care decisions. Members also have the right to ask questions about the way we conduct business, as well as the responsibility to learn about their health care coverage.

The member rights and responsibilities in this chapter are defined by the state of West Virginia and appear in the UniCare member welcome packets. You may view the Member Rights and Responsibilities in the Forms and Tools section of the Provider Resources page at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Members have certain rights and responsibilities when receiving their health care. They have a responsibility to take an active role in their care. We are committed to making sure members’ rights are respected while providing their health benefits. This also means providing access to UniCare network providers and the information members need to make the best decisions for their health and welfare.

Member Rights and Responsibilities

Member Rights

Members have the right to:

• Learn about their rights and responsibilities.
• Get the help they need to understand the Evidence of Coverage and Member Handbook.
• Learn about us, our services, doctors and other health care providers.
• See their medical records as allowed by law.
• Have their medical records kept private unless they tell us in writing that it’s OK for us to share them or it is allowed by law.
• Be part of honest talks about their health care needs and treatment options no matter the cost and whether their benefits cover them. Be part of decisions that are made by their doctors and other providers about their health care needs.
• Be told about other treatment choices or plans for care in a way that fits their condition.
• Get news about how doctors are paid.
• Find out how we decide if new technology or treatment should be part of a benefit.
• Be treated with respect, dignity and the right to privacy all the time.
• Know that we, their doctors and their other health care providers cannot treat them in a different way because of their age, sex, race, national origin, language needs or degree of illness or health condition.
• Talk to their doctor about things that are private.
• Have problems taken care of fast, including things they think are wrong, as well as issues about getting an OK from us, their coverage or payment of service.
• Be treated the same as others.
• Get care that should be done for medical reasons.
• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
• Choose their PCP from the PCPs in our provider directory that are taking new patients.
• Use providers who are in our network.
• Get medical care in a timely manner.
• Get services from providers outside our network in an emergency.
• Refuse care from their PCP or other caregivers.
• Be able to make choices about their health care.
• Make an advance directive (also called a living will).
• Tell us their concerns about UniCare and the health care services they get.
• Question a decision we make about coverage for care they got from their doctor.
• File a complaint or an appeal about UniCare, any care they get or if their language needs are not met.
• Ask how many grievances and appeals have been filed and why.
• Tell us what they think about their rights and responsibilities and suggest changes.
• Ask us about our Quality Improvement (QI) program and tell us how they would like to see changes made.
• Ask us about our utilization review process and give us ideas on how to change it.
• Know that the date they joined our health plan is used to decide their benefits.
• Know that we only cover health care services that are part of their plan.
• Know that we can make changes to their health plan benefits as long as we tell them about those changes in writing.
• Ask for their Evidence of Coverage and Member Handbook and other member materials in other formats such as large print, audio CD or Braille at no charge to them.
• Ask for an oral Interpreter and translation services at no cost to them.
• Use interpreters who are not their family members or friends.
• Know they will not be held liable if their health plan becomes bankrupt (insolvent).
• Know their provider can challenge the denial of service with their OK.

**Member Rights and Responsibilities**

**Member Responsibilities**

Members have the responsibility to:
• Tell us, their doctors and other health care providers what they need to know to treat them.
• Learn as much as they can about their health issue and work with their provider to set up treatment goals they agree on.
• Ask questions about any medical issue and make sure they understand what their provider tells them.
• Follow the care plan and instructions, to the best of their ability, that they have agreed on with their provider or other health care professionals.
• Do the things that keep them from getting sick.
• Make and keep medical appointments and tell their provider at least 24 hours in advance when they cannot make it.
• Always show their member identification (ID) card when they get health care services.
• Use the emergency room only in cases of an emergency or as their provider tells them.
• Tell us right away if they get a bill that they should not have gotten or if they have a complaint.
• Treat all UniCare staff and doctors with respect and courtesy.
• Know and follow the rules of their health plan.
• Know that laws guide their health plan and the services they get.
• Know that we do not take the place of workers’ compensation insurance.
• Tell us and their Department of Health and Human Resources (DHHR) case worker when they change their address, family status or other health care coverage.
CHAPTER 22: CULTURAL DIVERSITY AND LINGUISTIC SERVICES

Customer Care Center phone: 1-800-782-0095
Customer Care Center fax: 1-888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Cultural Diversity and Linguistic Services

Overview
At UniCare, we recognize that providing health care services to a diverse population may present challenges. We know it is important to continually increase your knowledge of, and ability to support, the values, beliefs, and needs of diverse patients. Differences in our members’ ability to read may add an extra dimension of difficulty when providers try to encourage follow-through on treatment plans. UniCare’s cultural diversity and linguistic services toolkit, called Caring for Diverse Populations, was developed to give you specific tools for breaking through cultural and language barriers in an effort to better communicate with your patients.

Sometimes the solution is as simple as finding the right interpreter for an office visit. Other times, a greater level of cultural awareness opens the door to the kind of interaction that makes treatment plans most effective: Has the patient been raised in a culture that frowns upon direct eye contact or receiving medical treatment from a member of the opposite sex? Is the patient self-conscious about his or her ability to read instructions?

The cultural diversity and linguistic services toolkit provides information you need to answer those questions and continue building trust. The toolkit enhances your ability to communicate with ease to a wide range of people about a variety of culturally-sensitive topics. Finally, the toolkit offers cultural and linguistic training to your office staff, enabling all aspects of an office visit to go smoothly.

We strongly encourage you to access the complete toolkit on the Provider Resources page of our website at www.unicare.com. Scroll to Health Education and select Caring for Diverse Populations. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

The toolkit contents are organized into the following sections:
- Resources to assist communication with a diverse patient population base
- Resources to communicate across language barriers
- Resources to increase awareness of cultural background and its impact on health care delivery
- Regulations and standards for cultural and linguistic services
- Resources for cultural and linguistic services

Resources to Assist Communication with a Diverse Patient Population Base
- Tips for providers and clinical staff
- A mnemonic to assist with patient interviews
- Help in identifying literacy problems
- An interview guide for hiring clinical staff who have an awareness of cultural competency issues

Resources to Communicate Across Language Barriers
- Tips for locating and working with interpreters
Resources to Increase Awareness of Cultural Background and Its Impact on Health Care Delivery
- Tips for speaking with people across cultures about a variety of culturally-sensitive topics
- Information about health care beliefs of different cultural backgrounds

Regulations and Standards for Cultural and Linguistic Services
This section identifies important legislation impacting cultural and linguistic services, including a summary of the Culturally and Linguistically Appropriate Services (CLAS) standards, which serve as a guide on how to meet these requirements.

Resources for Cultural and Linguistic Services
- A bibliography of print and Internet resources for conducting an assessment of the cultural and linguistic needs of your own practice’s patient population
- Staff and physician cultural and linguistic competency training resources
- Links to additional tools in multiple languages and/or written for limited English proficiency

The toolkit contains materials developed by and used with the permission of the Industry Collaboration Effort (ICE). ICE is a volunteer, multi-disciplinary team of providers, health plans, associations, state and federal agencies and accrediting bodies working collaboratively to improve health care regulatory compliance through education of the public. Locate more information about ICE on its website at www.iceforhealth.org.

In addition to the Caring for Diverse Populations toolkit, UniCare also offers a Cultural Competency Training, which can be accessed at the Provider Resources page of our website at www.unicare.com. Scroll to Health Education and click on Cultural Competency Training.

UniCare encourages providers to attend training in an effort to promote sensitivity to the special needs of the Medicaid population. UniCare supports continuous education through webinars, town hall meetings and provider orientations.

Cultural Diversity and Linguistic Services
Language Capability of Providers and Office Staff
UniCare strives to have a provider network that can meet the linguistic needs of our members. An important component is being aware of the language capabilities of you and your office staff. Use the Employee Language Self-Assessment Tool, found in the Caring for Diverse Populations toolkit, to help determine the level of proficiency with non-English languages. Please provide updates on the language capabilities of your office staff annually and at least every three years for yourself. In addition to meeting the linguistic needs of our members, UniCare strives to meet the ethnic and cultural preference of our members. An important component of this is capturing ethnicity data during the credentialing process. Language capability and provider ethnicity information will be reported in the provider directory to help members find a provider and/or office that can communicate in their preferred language and meets their cultural preferences.
Provide these updates using the Provider Change Form in the Forms and Tools section of the Provider Resources page at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Cultural Diversity and Linguistic Services

Interpreter Services

For those instances when you cannot communicate with a member due to language barriers, interpreter services are available at no cost to you or the member. UniCare provides over-the-phone and face-to-face Interpreters. Providers must notify members of the availability of interpreter services and strongly discourage the use of friends and family, particularly minors, to act as Interpreters. You or your office staff should document the member’s preferred language other than English in the member’s medical record, any refusal of interpreter services, and requests to use a family member or friend as an Interpreter.

Face-to-face interpreters for members needing language assistance, including American Sign Language, are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required. Over-the-phone interpreters are available 24 hours a day, 7 days a week.

To request interpreter services, providers and members should call UniCare’s Customer Care Center at 1-800-782-0095. For after-hours nurse services, call the 24/7 NurseLine at 1-888-850-1108. Take the following steps to initiate interpreter services when a member is on the phone line with you:

1. Give the member’s identification (ID) number to the Customer Care or 24/7 NurseLine associate.
2. Explain the need for an interpreter and state the language required.
3. Wait on the line while the connection is made.
4. Once connected to the interpreter, the Customer Care or 24/7 NurseLine associate introduces the UniCare member, explains the reason for the call, and begins the dialogue.

For members with hearing or speech loss, West Virginia Relay Service is a toll-free TDD service. Call 711 or the following numbers:

- For voice to TDD: 1-866-368-1634
- For TDD to voice: 1-800-982-8771

For additional information on interpreter services, access the Health Education section of the Provider Resources page at www.unicare.com. Scroll to Health Education and click on Interpreter Services or Interpreter Services Desktop Reference. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Cultural Diversity and Linguistic Services

Americans with Disabilities Act

Providers must comply with all applicable federal and state laws in assuring accessibility to all services for members with disabilities, pursuant to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973, maintaining the capacity to deliver services in a manner that accommodates the needs of its members. Providers contracted with UniCare are required by law to provide disabled persons full and equal access to medical services.

Although a review of the requirements of the law and implementing regulations can be daunting, providing full and equal access to persons with disabilities can be achieved by:
• Removing physical barriers.
• Providing means for effective communication with people who have vision, hearing or speech disabilities, including providing auxiliary aids as needed.
• Providing flexibility in scheduling to accommodate people with disabilities.
• Allowing extra time for members with disabilities to dress and undress, transfer to examination tables, and extra time with the provider in order to ensure the individual is fully participating and understands the information.
• Making reasonable modifications to policies, practices and procedures.

For more information on making changes to a practice to ensure ADA compliance, providers can refer to these additional resources:
• https://www.ada.gov
• https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm