Reimbursement Policy Updates

Effective March 1, 2015, reimbursement policies will be transitioning to the UniCare Health Plan of West Virginia, Inc. provider website. For policy specific information and future reference, please visit www.unicare.com.

What this means to you

Reimbursement policy language may have changed. These policies will serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by UniCare. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions.

What if I need assistance?

To view specific criteria, refer to the list of reimbursement policies at www.unicare.com or on our secure provider site at https://provider2.unicare.com/wps/portal/ebpmynuc (requires registration from first time users). For additional sources of information, please reference your Provider Manual, and/or your provider contract as a guide for reimbursement criteria. Your continued feedback is critical to our success. If you have questions, call our Customer Care Center at 1-800-782-0095.

Code and Clinical Editing

UniCare applies code and clinical editing guidelines to evaluate claims for accuracy and adherence to accepted national industry standards and plan benefits. We utilize sophisticated software products to ensure compliance with standard code edits and rules. These products increase consistency of payment for providers by ensuring correct coding and billing practices. Editing sources include but are not limited to Centers for Medicare & Medicaid Services National Correct Coding Initiative (NCCI), Medical Policies, and Clinical Utilization Management (UM) Guidelines. UniCare is committed to working with you to ensure timely processing and payment of claims.

Policy updates:

Inpatient Facility Transfers
(Policy 13-002, effective March 1, 2015)

UniCare allows payment for services rendered by both the sending and the receiving facility when a patient is admitted to one acute care facility and subsequently transferred to another acute care facility for same episode of care, in compliance with federal and/or state guidelines regarding facility transfers payment.

In the absence of such guidelines, UniCare will use the following criteria:

- Transferring facility will receive a calculated per diem rate based on length of stay not to exceed the amount that would have been paid if the patient had been discharged to another setting
- Receiving facility will receive full DRG payment

This policy only affects those facilities reimbursed for inpatient services by a DRG methodology.

www.unicare.com
To view specific criteria for Inpatient Facility Transfers, please refer to the reimbursement policy at www.unicare.com.

**Inpatient Readmissions**  
(Policy 12-001, effective **March 1, 2015**)  
UniCare will be implementing inpatient readmission rules effective **March 1, 2015** following state and CMS guidelines.

Claims identified as a readmission will be subject to the following:

- Readmissions occurring on the same day for symptoms related to, or for evaluation and management of, the prior stay’s medical condition are considered part of the original admission and will be considered a single claim for processing.
- Readmissions occurring within 2 – 7 days will be subject to clinical reviews. If the clinical review indicates that the second admission is for the same or similar diagnosis, it may be considered an extension of the initial admission for the purposes of reimbursement. If substantiated, this may result in a request to refund the payment for the second admission.

**What criteria are utilized?**

UniCare will utilize clinical criteria and licensed clinical medical review for readmissions from day two to day seven in order to determine if the second admission is for:

- The same or closely related condition or procedure as the prior discharge
- An infection or other complication of care
- A condition or procedure indicative of a failed surgical intervention
- An acute decompensation of a coexisting chronic disease
- A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period
- An issue caused by a premature discharge from the same facility
- A reason that is medically unnecessary

Inpatient Readmission rules only affect those facilities reimbursed for inpatient services by a diagnosis related group (DRG) methodology.

**Are there exclusions?**

Yes. The following are excluded:

- Admissions for the medical treatment of primary psychiatric disease and rehabilitation care
- Planned readmissions
- Patient transfers from one acute care hospital to another
- Patient discharged from the hospital against medical advice

UniCare reserves the right to recoup and/or recover monies previously paid on a claim that falls within the guidelines of a readmission.

To view specific criteria for Inpatient Readmissions, please refer to the reimbursement policy at www.unicare.com.