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CHAPTER 1: INTRODUCTION

Welcome

Welcome and thank you for being a 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 certain counties in West Virginia. BMS manages the Mountain Health Trust Medicaid managed care program for West Virginia and is administered by the Department of Health and Human Resources (DHHR).

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

Behavioral Health Services

Overview

Behavioral Health Services are an integral part of health care management at UniCare. Our program 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.
Services provided to people with serious emotional disturbances and their families are best delivered based on the System of Care Values and Principles that are endorsed by SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Person-centered and family-focused with the needs of the person and family dictating the types and mix of services provided.
- Community-based with the focus of services as well as management and decision making responsibility resting at the community level.
- Culturally competent with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.
- Comprehensive, covering an array of services that address physical, emotional, social, educational and cultural needs.
- Personalized as evidenced by an individualized service plan formulated to meet unique needs and potential.
- Delivered in the least restrictive, most normative environment that is clinically appropriate.
- Integrated and coordinated between agencies and include mechanisms for planning, developing and coordinating services inclusive of case management or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the person and their family.
- Delivered without regard to race, religion, national origin, sex, physical disability or other characteristics.
- Oriented to recovery, providing services that are flexible and evolve over time.

Introduction

Goals

The goals of UniCare’s Behavioral Health program are to:

- Ensure and expand service accessibility to eligible members
- Promote the integration of the management and delivery of physical and behavioral health services
- Achieve quality initiatives including those related to HEDIS, NCQA and Bureau of Medical Services (BMS) performance requirements
- Work with members, providers and community supports to provide recovery tools and create an environment that supports members’ progress toward their recovery goals
- Ensure utilization of the most appropriate, least restrictive, medical and behavioral health care in the right place at the right time

Introduction

Objectives

The objectives of the UniCare Behavioral Health program are to:

- Promote continuity and coordination of care among physical and behavioral health care practitioners
- Enhance member satisfaction by implementing individualized and holistic support and care plans that allow members to achieve their recovery goals
- Provide member education on treatment options and pathways toward recovery
- Provide high quality case management and care coordination services that identify member needs and address them in a personal and holistic manner
• Work with treatment service providers to ensure the provision of medically necessary and appropriate care and services, including inpatient care, alternative care settings, and outpatient care at the least restrictive level
• Enhance provider satisfaction and success through collaborative and supportive relationships built on mutually agreed upon goals, outcomes and incentives
• Promote collaboration between all health care partners to achieve recovery goals through education, technological support and the promotion of recovery ideals
• Use evidence-based guidelines and clinical criteria and promote their use in the provider community
• Maintain compliance and accreditation standards with local, state and federal requirements

Introduction
Guiding Principles of UniCare’s Behavioral Health Program

A primary guiding principal of the UniCare Integrated Behavioral Health Program is recovery. Recovery is a member-driven process in which people find their paths to work, learn and participate fully in their communities Resiliency is the ability to live a fulfilling and productive life despite the continued presence of a disability. Physical and behavioral health services are rendered in a manner that allows the achievement of recovery for members experiencing mental illness and substance use disorders. Treatment supports the development of resiliency for those facing mental illness, serious emotional disturbance and/or substance use disorder issues.

The Substance Abuse and Mental Health Services Administration (SAMHSA) released a consensus statement on mental health recovery reflecting the desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery identified by SAMHSA are:

Self-direction: members lead, control and determine their own paths of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life.

Individualized care: There are multiple pathways to recovery based on an individual's unique strengths and resiliency, as well as his or her needs, preferences and experiences including past trauma and cultural background.

Empowerment: members have the authority to choose from a range of options and to participate in all decisions, including the allocation of resources, which will affect their lives and are educated and supported in so doing.

Holistic: Recovery embraces all aspects of life, including housing, employment, education, mental and health care treatment and services, complementary and naturalistic services (e.g., recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person.

Nonlinear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths-based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals.

Peer support: Mutual support including the sharing of experiential knowledge, skills and social learning plays an invaluable role in recovery.
Respect: Community, systems and societal acceptance and appreciation of consumers — including protecting their rights and eliminating discrimination and stigma — are crucial to achieve recovery.

Responsibility: members have a personal responsibility for their own self-care and journeys of recovery.

Hope: Recovery provides the essential and motivating message of a better future — that people can and do overcome the obstacles that confront them. Hope is internalized but can be fostered by peers, family, friends, providers and others. Hope is the catalyst of the recovery process.

Resiliency is the ability of an individual or family to cope and adapt to the challenges and changes brought on by distress or disability. Becoming resilient is a dynamic developmental process that requires patience and effort to pursue steps that enhance positive responses to adverse circumstances. Accepting and managing one’s life in a manner that displays optimism for personal successes manifested by traits of self-efficacy and high self-esteem is achieved by building resiliency. Resilience is learned and developed.

Introduction

Provider Success

We believe the success of providers is necessary to achieve our goals. We are committed to supporting and working with qualified providers to ensure that we jointly meet quality and recovery goals. Our commitment includes:

- Supporting providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person
- Simplifying precertification rules, referrals, claims and payment processes to help providers reduce administrative time and focus on the needs of members

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.
Introduction

Health Plan Clinical Staff

All clinical staff is licensed and has at least two years of prior clinical experience. Our Medical Director is board certified in psychiatry. Our trained and experienced team of clinical care managers, case managers and support staff provide high quality care management and care coordination services to our members and work collaboratively with all providers.

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: www.UniCare.com. Throughout this manual, we often will refer you to items located on the Provider Resources page. To access this page, please follow these web 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.
4. To access this Behavioral Health Provider Manual:
   - Scroll to the Provider Communications section.
   - Select Provider Manual and Important Updates and then Behavioral Health Provider Manual to view a PDF of this manual.

Using the Behavioral Health Provider Manual: Click on any topic in the “Table of Contents” to view that chapter. Click on 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: 1-800-782-0095. Hours: Monday to Friday, 8 a.m. to 6 p.m.
CHAPTER 2: LEGAL AND ADMINISTRATIVE REQUIREMENTS

Legal and Administrative Requirements

Privacy Practices

UniCare’s latest Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant privacy and security statements may be found in the Notice of Privacy Practices. For more information, locate the Policies, Manuals and Guidelines section on 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.

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 re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please contact the Customer Care Center: 1-800-782-0095.

Legal and Administrative Requirements

Updates and Changes

The Behavioral Health 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

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 3: CONTACTS

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

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| Availity                         | **Availity Client Services**  
Phone: 1-800-AVAILITY (1-800-282-4548) |
| Address                          | General address for all correspondence, including initial claims submission:  
UniCare Health Plan of West Virginia, Inc.  
P.O. Box 91  
Charleston, WV 25321-0091  
Note: For faster service, please indicate how you want the correspondence routed. For example: “Attn: Initial Claims Department” |
| Authorization                    | 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**  
Psychological Testing Fax: **1-855-325-5557**  
Hours: Monday to Friday, 8 a.m. to 5 p.m.  
Website: [www.UniCare.com](http://www.UniCare.com) |
| Benefits, eligibility, verifying Primary Care provider (PCP) and general provider questions | **Customer Care Center**  
Phone: **1-800-782-0095**  
TTY: **1-866-368-1634**  
Hours: Monday to Friday, 8 a.m. to 6 p.m.  
After hours, call MedCall® to verify member eligibility 24 hours a day, 7 days a week: **1-888-850-1108** |
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| **Case Management Referrals** | Phone: **1-866-655-7423**  
Hours: Monday to Friday, 8 a.m. to 6 p.m.  
Fax: **1-866-387-2959** | Website: [www.UniCare.com](http://www.UniCare.com)  
Response within three business days |
| **Claims Overpayment** | Mail overpayment to:  
UniCare Health Plan of West Virginia, Inc.  
Attn: Overpayment Recovery  
P.O. Box 92420  
Cleveland, OH 44193  
Address for overnight delivery:  
UniCare Health Plan of West Virginia, Inc.  
Attn: Overpayment Recovery  
Lockbox 92420  
4100 West 150th Street  
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** |
| **Fraud and Abuse** | **Fraud Hotline**  
Phone: **1-877-660-7890** or **1-757-518-3633**  
Hours: Monday to Friday, 8 a.m. to 6 p.m.  
Website: [www.UniCare.com](http://www.UniCare.com)  
Address:  
UniCare Medicaid Special Investigations Unit (MSIU)  
4425 Corporation Lane, Mail Stop VA31  
Virginia Beach, VA 23462 |
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| 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** |
| Interpreter Services          | **Customer Care Center**  
  Phone: **1-800-782-0095**  
  Hours: Monday to Friday, 8 a.m. to 6 p.m.  
  After hours, call MedCall 24 hours a day, 7 days a week: **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 MedCall TTY line: **1-800-368-4424** |
| Members with hearing or speech loss | West Virginia Relay Service is a toll free Telecommunication Device for the Deaf (TDD) service. Call **711** or the following numbers:  
  - For voice to TDD, call: **1-800-982-8772**  
  - For TDD to voice, call: **1-800-982-8771**  
  Website: [www.westvirginiarelay.com](http://www.westvirginiarelay.com) |
| Pharmacy Preferred Drug List (PDL) inquiries | The PDL is considered part of the pharmacy service and is located on the BMS website: [https://dhhr.wv.gov/bms/Pages/default.aspx](https://dhhr.wv.gov/bms/Pages/default.aspx). In the providers section, click on the link for Pharmacy. In the top navigation menu, click the link for **Preferred Drug List**. Scroll to select the most recently posted version. |
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.-6 p.m.
Website:  www.UniCare.com

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 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.

Covered and Noncovered Services

Pharmacy Benefits

Pharmacy benefits are not covered under UniCare; they are covered under the traditional fee-for-service Medicaid program. For more information, visit https://dhhr.wv.gov/bms/Pages/default.aspx.

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:

- 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 Human Immunodeficiency Virus (HIV) contact
- Referral for Women, Infants, and Children (WIC) services and information sharing
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.-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 treated by UniCare providers is, in fact, a currently-enrolled UniCare member.

To prevent fraud and abuse, providers should confirm the identity of the person presenting the identification (ID) card. Providers must verify a member’s eligibility before services are rendered. Because eligibility can change, verify eligibility at every visit. Remember that claims submitted for services rendered to non-eligible 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 in the following ways:

- Log on to the secure UniCare provider website: Go to https://www.availity.com and 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.
- Call UniCare’s Interactive Voice Response (IVR) system: 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 National Provider Identifier (NPI) number or your TIN.

Member Eligibility
Member Identification Cards

Following enrollment, eligible enrollees will receive their member ID cards:

- UniCare-Issued member ID Card
- State-Issued Medicaid Managed Care member ID Card

Member Eligibility
UniCare-Issued Member Identification Card

The member ID card, issued by UniCare, authorizes Behavioral Health Services for members. This plastic ID card is retained by members as long as they are managed by the same primary care provider (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, MedCall®, Vision, Dental, Eligibility, Pharmacy, 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. If the member transfers to a new PCP, UniCare issues a new ID card.

**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.
CHAPTER 6: UTILIZATION MANAGEMENT

Utilization Management Phone: 1-866-655-7423
Utilization Management Fax: 1-855-402-6983
Hours of Operation: Monday to Friday, 8 a.m.-5 p.m.

Please note: UniCare ensures availability of Utilization Management (UM) decision staff 24 hours a day, 7 days a week.

Utilization Management
Behavioral Health Utilization Management

As a corporation and as individuals Utilization Management (UM) Decisions are governed by the following statements:

- UM-decision making is based only on appropriateness of care and service and existence of coverage.
- Practitioners or other individuals are not specifically rewarded for issuing denial of coverage care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denial of benefits.
- 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.

Utilization Management
Overview

UniCare’s Utilization Management is a cooperative effort with providers to promote the right care, to the right member, at the right time, in the appropriate setting.

The UM department takes a multidisciplinary approach to meet the medical and psycho-social needs of our members. UniCare’s decision-making process incorporates the most up-to-date UM standards from the National Committee for Quality Assurance (NCQA).

The decision-making criteria used by the UM department is evidence-based and consensus-driven. We periodically update utilization management policies and guidelines 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 utilization management policies and guidelines are available on 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 or by contacting the UM department: 1-866-655-7423. Hours: Monday to Friday, 8am-5pm.

The Utilization Management department is staffed with licensed behavioral health practitioners and non-clinical support staff. The department provides the following service request reviews:

- Prior Authorizations
- Continued stay authorization
- Post-service clinical claims payment
If you disagree with a UM decision and want to discuss the decision with the physician reviewer, call the UM department: **1-866-655-7423**.

**Utilization Management**  
**Authorizations**

Authorizations are based on the following:

- Benefit coverage
- Established medical necessity criteria
- Community standards of care

**Utilization Management**  
**Services Requiring Prior Authorization**

Please see the [Provider Resources](#) page on [www.UniCare.com](http://www.UniCare.com). Scroll to the [Forms and Tools](#) section and select [UM Authorization](#) to check which services require prior authorization.

**Utilization Management**  
**Authorization Requests for Admission to Inpatient, Residential Treatment and Partial Hospital Levels of Care**

Notify the UM department by fax or phone of a request to admit to an acute level of care for behavioral health or substance abuse. Have the following information ready:

- Member name and identification (ID) number, if available
- Diagnosis with the current International Classification of Diseases code
- Date of admission and third-party liability information (if applicable)
- Facility name
- Primary Care provider (PCP) name, if available
- Specialist or attending Physician name, if available
- Clinical indications for the request
- Level of care
- Medications
- Treatment plan, including estimated discharge date
- Psycho-social status and history
- Exceptional or special needs issues
- Response to previous treatment
- Family involvement
- Expected outcomes
- Discharge plans
- Discharge planner name and extension

Hospitals must notify the UM department of inpatient medical admissions within 24 hours of admission or by the next business day. UM staff will request clinical information from the hospital on the same day they are notified of the member’s admission.

Inpatient claims billed on a UB-04 form should be billed with a revenue code. Professional and Ancillary services not included in the facility fee can be billed separately on a CMS-1500 form.
Utilization Management

Authorization Requests for Continued Stay Days: Inpatient, Residential Treatment and Partial Hospital Levels of Care

Before the initial authorization time period expires, notify the UM department to request additional medical necessary covered days. Have the following information available:

- Member name and identification (ID) number, if available
- Any changes in Diagnosis with the current International Classification of Diseases code
- Any changes in the Specialist or attending Physician providing care, if available
- Changes in clinical presentation based upon applied interventions
- Changes in Medications, if any
- Treatment plan update, including any revision in estimated discharge date
- Changes in or newly identified exceptional or special needs issues
- Updated discharge plan

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 of the continued stay request.

If the information meets medical necessity review criteria, we will approve the request within 24 hours of receipt of the information.

We will notify providers of the decision within 24 hours. We will send written notification to the member and requesting provider of any denial or modification of the request.

Inpatient claims billed on a UB-04 form should be billed with a revenue code. Professional and Ancillary services not included in the facility fee can be billed separately on a CMS-1500 form.

Utilization Management

Requesting Authorization

UniCare will implement the standard behavioral service authorization format, or Care Connection form for electronic requests. UniCare may modify the Department’s standard behavioral service authorization format by request. Please see the Behavioral Health Timeliness of Decisions on Requests for Authorization section for authorization time frames.

Utilization Management

Authorization Requests for Outpatient Level of Care Services

UniCare will implement the electronic authorization request process as required, and will accept telephonic requests and fax requests.

Utilization Management

Electronic Authorization Requests

UniCare will implement the electronic authorization request process as required, and will accept telephonic requests and fax requests. UniCare will implement the standard behavioral service authorization format, or Care Connection form for electronic requests. UniCare may modify the Department’s standard behavioral service authorization format by request.
Utilization Management
Fax Authorization Requests
A fax form is available at www.UniCare.com. The dedicated behavioral health fax number is 1-855-402-6983.

Utilization Management
Telephone Authorization Requests
Telephone authorization requests will be processed 24 hours a day, 7 days a week. The dedicated behavioral health phone number is 1-866-655-7423.

Utilization Management
Authorization requests for Continued Treatment for Outpatient Level of Care Services
Two business days before the initial authorization time period expires, notify the UM department to request additional medical necessary covered services by submitting an electronic batch authorization request file, faxing a completed form, or telephonic with the information contained on the form.

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, typically by the same means in which the authorization was received. If we do not obtain a response within the specified time frame after receiving the request, we will issue a Notice of Action: Denial – Not Medically Necessary letter to the member and provider.

Utilization Management
Denial of a Request for Service
When information submitted with a request does not appear to meet medical necessity, we will submit that information to an appropriately licensed Practitioner for further review.

Only a UniCare authorized appropriately licensed Practitioner can deny a request for services for lack of medical necessity.

If a request for services is denied the requesting provider will be notified verbally and in writing of the following:

- The decision
- The process for appeal
- How to reach the reviewing Physician for peer-to-peer discussion of the case

Providers may contact the Physician Clinical Reviewer to discuss any UM decision by calling the UM department.
Utilization Management

Post-Service Clinical Claims Review

Post-service clinical claims review determines the medical necessity and/or level of care for services that were provided without obtaining the required pre-service or continued stay authorization. For inpatient admissions where no notification was received, and no patient days were authorized, facilities are required to submit a copy of the medical record with the claim.

Utilization Management

Behavioral Health Timeliness of Decisions on Requests for Authorization

| Behavioral Health | 1.  Urgent, pre-service requests: within 72 hours of request  
|                   | 2.  Urgent concurrent requests: within 24 hours of request  
|                   | 3.  Routine, nonurgent requests: within 7 calendar days of receiving request  
|                   | 4.  Post-service review requests: within 14 days of request  

Notes:

- These time frames are requirements but, within these maximum time frames, actual decision times will vary depending on the member’s clinical situation and the availability of information necessary to make the decision.
- Post-service review refers to a review of an authorization request submitted for care that has already been delivered. This should not be confused with any medical record review process carried out in conjunction with compliance or quality of care activities.

Utilization Management

Necessity Determination and Peer Review

- The reviewer, or the requesting provider, may initiate a peer-to-peer conversation with the treating provider to discuss the relevant clinical information with the clinician working with the member.
- If an adverse decision is made by the reviewer without such a peer-to-peer conversation having taken place (as may occur when the provider is unavailable for review), the provider may request such a conversation. In this case, we will make a medical director or other appropriate practitioner available to discuss the case with the requesting provider. This conversation may result in the decision being upheld or changed.
- If you disagree with a UM decision and want to discuss the decision with the physician reviewer, call the UM department: 1-866-655-7423.
- Members requesting providers and applicable facilities are notified of any adverse decision within the notification time frames, which are based on the type of care requested and in conformance with regulatory and accreditation requirements.
Utilization Management
Behavioral Health Referrals

A referral is not necessary for behavioral health services. Members may self-refer to any behavioral health care provider in UniCare’s network.

Note: UniCare does not perform triage and referral services.

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.
CHAPTER 7: 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.-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.

Providers rendering behavioral health services should bill UniCare using appropriate behavioral health codes. All claims for behavioral health services should be billed to UniCare. UniCare uses commercial processing, coding guidelines and bundling edits. Refer to the West Virginia Bureau for Medical Services (BMS) website: https://dhhr.wv.gov/bms/Pages/default.aspx. Scroll down and click the Claims Processing link on the left side of the screen. Select from the available links for Billing Tips, Estimated Provider Payments Schedule, Frequently Asked Questions, or Provider Information. Click the email link to send an email to the claims doctor.

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 and Billing
McKesson ClaimsXten

UniCare uses claims editing software from McKesson called ClaimsXten. ClaimsXten incorporates the McKesson editing rules that determine whether a claim should be paid, rejected or undergo manual processing. These editing rules assess Current Procedural Terminology® (CPT) and Healthcare Common Procedure Coding System (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.

ClaimsXten may be updated periodically. UniCare will notify providers in advance of changes to ClaimsXten rules. For the latest information and current ClaimsXten rules, log on to our website: www.UniCare.com.
Claims and Billing

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 UniCare website to pre-screen claims and inquire on claim disposition. Descriptions of these rules are available on our secure website: www.UniCare.com.

Claims and Billing

Submitting Clean Claims

Claims submitted correctly the first time are called clean claims, 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 form. 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 Health Insurance Portability and Accountability Act (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
- CMS-1450 (UB-04) for institutional services: www.cms.gov/Regulations-and-Guidance

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

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 Ambulance  
                        | o Behavioral Health                                               | Within 180 days of service date |
| CMS-1450 Claim Form   | Hospitals, institutions, psychiatric facilities 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>Third-Party Liability (TPL) or Coordination of Benefits (COB)</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>Checking Claim Status</td>
<td>Claim status may be checked any time by calling the Customer Care Center Interactive Voice Response (IVR) system. In addition, copies of RAs are available online through Availity.</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>Claim Follow-Up Request</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 <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 RA.</td>
</tr>
</tbody>
</table>
**Action** | **Type of Service to be Billed** | **Time Frame**
---|---|---
Mailback Form | 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. | 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.

Claim Filing with Wrong Health Plan/Insurance Carrier | 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. | 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.

Provider Dispute | Submit a claim reconsideration request in writing to: UniCare Health Plan of West Virginia, Inc. Attn: Claims Reconsideration P.O. Box 91 Charleston, WV 25321-0091 Phone: 1-800-782-0095 Fax: 1-800-668-8389 | 365 days from the receipt of our RA.

UniCare’s Response to Provider Dispute Resolution Request | This process provides UniCare with response time to investigate and make a determination. | 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.

**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 (FAQs) 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.-7:30 pm

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 National Provider Identifier (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, Psychiatrists Dentists Chiropractors and Psychologists
- **Type 2**: Hospitals and medical groups, including, but not limited to, hospitals, group practices, Compressive Behavioral Health Centers (COMPs), Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs), Licensed Behavioral Health Centers (LBHCs) 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: https://nppes.cms.hhs.gov/NPPES. Click Apply Online for an NPI, Login or Create Login to View or Update your NPI Data. Or, obtain a paper application by calling NPPES: 1-800-465-3203.

The following websites offer additional NPI information:

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

**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: https://dhhr.wv.gov/bms/Pages/default.aspx.

**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 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: https://dhhr.wv.gov/bms/Pages/default.aspx.

Providers may balance bill a member when prior authorization of a covered service is denied. However, the provider must establish and demonstrate compliance with 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 non-specific 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, including Medicare. Indicate “Other Coverage” information on the appropriate claim form. If you need to coordinate benefits, include at least 1 of the following items from the other health care program when submitting a Coordination of Benefits (COB) claim:

• Third-party 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 1 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.

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 a 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 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.

**UniCare will reimburse at least 100 (one-hundred) percent of the current fee-for-service Medicaid fee schedule to in-network behavioral health provider, unless such provider agreed to an alternative payment schedule.**

### Claims and Billing

#### Monitoring Submitted Claims

Monitor claims status through the Customer Care Center’s IVR system: **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 in to the secure UniCare provider website at [https://www.availity.com](https://www.availity.com) with your user ID and password. Or, if you don’t have an account, select **Register**. To register, you will need your federal TIN, organizational name and NPI.

#### 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.

#### 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.

Provider 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](http://www.caqh.org) and under **CAQH Solutions Login**, select EnrollHub®.
Claims and Billing

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 in writing an acknowledgement of the notification.

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.

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 92420
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 Cost Containment department by phone: 1-800-345-7029.

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 7 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 re-submission.
- 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: 1-800-782-0095.
- Check the secure UniCare provider website 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.
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

Claims 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 10: Grievances and Appeals.

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 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.

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>Problem</td>
<td>Explanation</td>
<td>Resolution</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</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 NDC number 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 or blood products require a manufacturer’s invoice. For drugs/injections, the NDC number is required.</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>
</tbody>
</table>

**Claims and Billing**

**Inpatient Acute Care**

UniCare is responsible for:

- All claims incurred within the inpatient behavioral health treatment settings covered by managed care
- All claims incurred during involuntary inpatient facility stay.

UniCare is not responsible for:

- Any payments for inpatient behavioral health services that are covered by fee-for-service
• Claims incurred within the inpatient behavioral health or residential treatment setting if a member entered the treatment setting as a fee-for-service member
• Claims incurred within the inpatient behavioral health treatment settings if a member entered the treatment setting as a member of another MCO
• Any claims incurred during inpatient stay at Mildred Mitchell Bateman Hospital and William R. Sharpe Jr. Hospital, if a member is between the ages of 22 and 64
• Any claims incurred during residential treatment facility stay for individuals 21 years of age or older

**UniCare is required to reimburse providers for court-ordered treatment services that are covered by UniCare under the Medicaid State Plan.**

**Claims and Billing**

**Inpatient Care - Children**

UniCare is responsible for:
• All claims incurred within the inpatient behavioral health or psychiatric treatment settings covered by managed care
• All claims incurred during involuntary inpatient facility stay.

UniCare is not responsible for:
• Any payments for inpatient behavioral health services that are covered by fee-for-service
• Claims incurred within the inpatient behavioral health or psychiatric treatment setting if a member entered the treatment setting as a fee-for-service member
• Claims incurred within the inpatient behavioral health or psychiatric treatment settings if a member entered the treatment setting as a member of another MCO.

**UniCare is required to reimburse providers for court-ordered treatment services that are covered by UniCare under the Medicaid State Plan.**
CHAPTER 8: 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.-6 p.m.

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
- Incarceration
- Loss of benefits
- Member has other non-government or government sponsored health coverage
- Permanent change of residence out of the service area
- Voluntary disenrollment

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: 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 daily and 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
- Incarceration
- Loss of benefits
- Member has other non-government 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 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

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 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 9: 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 Number: 1-866-387-2968
Hours of Operation: Monday to Friday, 8 a.m.-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. UniCare’s grievances and appeals process meets all requirements of state and federal law and accreditation agencies.

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

Complaint: An expression of dissatisfaction made about the MCO decision or services received from the MCO when an informal grievance is filed; some complaints may be subject to appeal.

Grievance: 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. 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 adverse benefit determination.

An expedited appeal is defined as follows:

Expedited appeal: 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 defined as follows:

Inquiry: 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 defined as follows:

Action: 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, grievances 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 up to 90 days from the date the provider became 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 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

Requests 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 claim 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.

If a provider is not satisfied with the outcome of the review process, additional steps may be taken, per the UniCare Provider Agreement:
Grievances and Appeals
Providers: Resolution and Arbitration

Providers who have exhausted our grievance and appeal resolution process and are dissatisfied with our resolution have the right to file a grievance or appeal, as applicable, with arbitration (handled per the Provider Agreement). UniCare handles all grievances and appeals in a confidential manner; we do not discriminate against a provider for filing a grievance or an appeal.

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 about any matter other than an adverse benefit determination, 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 adverse benefit determination.

Grievances and Appeals
Members: When to File

Members have the following time periods to file:

- **Grievance:** at any time
- **Grievance appeal:** within 30 calendar days of the date when the grievance was resolved
- **Appeal:** within 60 calendar days from the date on the notification letter of initial denial

Grievances and Appeals
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 Primary Care provider’s (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 Primary Care provider

Members will be required to sign a Designation of Authorization 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. 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. 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 mail 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 adverse benefit. 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.

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.

**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.

**Grievances and Appeals**

**Members: Extensions**

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. We maintain documentation of any extension request.

In the notice to the member of the extension, UniCare will notify the member of his or her right to file a grievance if they disagree with the extension.

**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: **1-800-782-0095**.

**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 2 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 decision after exhausting UniCare’s grievances and appeals process, the member has the right to file an appeal with the Bureau of Medical Services (BMS) and request a state fair hearing. 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. UniCare members can request a State Fair Hearing within 120 calendar days from the date of the Notice of Adverse Resolution. The request must be submitted in writing to the state of West Virginia:

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 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 Cultural and Linguistic 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 10: CREDENTIALING AND RECREREDENTIALING

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.-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 3 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.

If you prefer not to use the CAQH Universal Provider Datasource for initial credentialing, please visit the WV website www.wvinsurance.gov > Resources – Forms > Uniform Credentialing to download and complete the standard WV credentialing application.

Credentialing and Recredentialing
Council for Affordable Quality Healthcare

UniCare strongly encourages West Virginia providers to use the CAQH 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 (ID) 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](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 (National Provider Identification [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:
  - State license(s) applicable to your provider type
  - Current DEA Certificate, if applicable
  - Current Controlled and Dangerous Substances Certificate, if applicable
  - Current malpractice insurance face sheet
  - Summary of all pending or settled malpractice case(s) within the past 10 years
  - Curriculum vitae
  - Current signed attestation
  - 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](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 click 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. Click 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.-9 p.m.; Friday, 7 a.m.-7 p.m.
Email: caqh.updhelp@acsgs.com
Fax: 1-866-293-0414

After you complete registration and attestation, a fax coversheet will be available on the CAQH website to use when faxing your supporting documents. You must use this approved coversheet.

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

Credentialing and Recredentialing
Hospitals, Comprehensive Behavioral Health Centers and Licensed Behavioral Health Centers

Hospitals must complete a UniCare Facility Application for each facility with a separate Tax Identification Number (TIN), along with supporting documents. A Behavioral Health Addendum must be completed for each location even if the TIN is the same. UniCare does not require rosters for Hospital / Facility based providers. Facilities will need to be recredentialed every 3 years.

Comprehensive Behavioral Health Centers (COMPs) and Licensed Behavioral Health Centers (LBHCs) must complete a UniCare Facility Application for the organization and UniCare Facility Addendum for each location. UniCare may request a roster of all practitioners with submission. (Note: licensed practitioners will not be individually credentialed). COMPs and LBHCs will be recredentialed every 3 years.

Hospital, Comprehensive Behavioral Health Centers and Licensed Behavioral Health Centers are expected to complete a UniCare Facility Application when adding any new facility after being credentialed and complete a Behavioral Health Addendum and if applicable.

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: 1-800-782-0095.
Behavioral Health Group Adding a Provider

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

Solo Provider or Group Interested in Contracting with UniCare

If you are a solo provider or 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 Provider Agreement (whichever is applicable)
- Provider Credentialing 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 4 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.

Credentialing and Recredentialing

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

Nondiscrimination Policy

UniCare will not discriminate against any applicant for participation in its Networks or Plan Programs 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 that are provided to the Covered Individuals to meet their needs and preferences, this information is not required in the credentialing and recredentialing process. Determinations as to which practitioners/HDOs require additional individual review by the CC are made according to predetermined
criteria related to professional conduct and competence as outlined in UniCare Credentialing Program Standards. CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

**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, HDOs and 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.
CHAPTER 11: ACCESS STANDARDS AND ACCESS TO CARE

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.-6 p.m.

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), 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 Toolkit and Cultural and Linguistic Training. We have included an introduction to this training in Chapter 20: 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: www.UniCare.com. Click on 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

Behavioral Health Access to Care Standards

This grid outlines standards for timely and appropriate access to quality behavioral health care.

| Behavioral Health | 1. Emergent: Immediately  
|                   | 2. Emergent, Non-Life-Threatening/Crisis Stabilization; Within six hours of request.  
|                   | 3. Urgent: Within 48 hours of referral/request  
|                   | 4. Outpatient treatment by a BH provider (routine visits) within 10 business days.  
|                   |   a. Outpatient following discharge from an IP Hospital: Within 7 days of discharge.  
|                   |   b. Members should be seen within 45 minutes of their scheduled appointment time (emergencies excluded)  
|                   |   c. For those agencies who have an open access process meaning the member walks in and waits to be seen without an appointment, the provider needs to see the member within three hours or offer them an appointment.  |
## Definitions

**Emergent**: Treatment is considered to be an on-demand service and does not require precertification. Members are asked to go directly to emergency rooms for services if they are either unsafe or their conditions are deteriorating.

**Emergent, Non-Life Threatening/Crisis Stabilization**: On demand is urgent but not life threatening and can be seen in the office within 6 hours or directed to the emergency room if they can’t be seen in the office.

**Urgent**: Means a service need that is not emergent and can be met by providing an assessment and services within 48 hours of the initial contact. If the member is pregnant and has substance use problems she is to be placed in the urgent category.

**Routine**: Means a service need that is not urgent and can be met by receiving treatment within 10 calendar days of the assessment without resultant deterioration in the individual's functioning or worsening of his or her condition.

## 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 reasonable 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 providers must have a system in place to ensure members may call after hours with questions or concerns. UniCare monitors providers compliance with after-hours access standards on a regular basis. We recommend that providers advise their answering services to participate in any after-hours monitoring. Failure to comply may result in corrective action. Providers 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. If your
organization has 24/7 crisis service, the member should be directed to this service prior to contacting 911.

- Forward non-emergency member calls directly to the 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.

**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 on-call provider in a non-emergency situation.
- Must provide instructions in English, Spanish and any other language appropriate to the provider’s practice.

We offer the following suggested text for answering machines:

“Hello, you have reached [insert 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 concern or question, please call [insert contact phone or pager number]. You will receive a return call from the on-call provider within [time frame].”

**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.

**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

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 psycho-social 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 2 business days of the decision. Members and providers may appeal the decision by following the procedures in Chapter 10: Grievances and Appeals in this manual. Reasons for continuity of care denials include, but are not limited to, the following:

- Course of treatment is complete
- Member is ineligible for coverage
- Condition is not a qualifying condition
- 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 15 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: 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 on-going care if it has been greater than:

- 90 days after the member enrolled in UniCare
- 9 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 National Provider Identifier (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: [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.

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.
CHAPTER 12: PROVIDER ROLES AND RESPONSIBILITIES

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.-6 p.m.

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, Primary Care providers (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.

Provider Roles and Responsibilities
Behavioral Health Provider Roles and Responsibilities
At UniCare, our behavioral health care benefit is fully integrated with the rest of our health care programs. This coordination of healthcare resources requires certain roles and responsibilities for behavioral health providers, including the following:

- Participate in the care management and coordination process for each UniCare member under your care, as clinically appropriate.
- Seek prior authorization for all services that require it.
- Notify the member's PCP of any significant changes in the member's status and/or change in the level of care as clinically appropriate.
- Ensure that members receiving inpatient psychiatric services are scheduled for an outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within 7 calendar days from the date of the member's discharge.
- Encourage members to consent to the sharing of substance abuse treatment information with other providers involved in the member’s care as clinically appropriate.

Provider Roles and Responsibilities
Coordination of Behavioral Health and Physical Health Treatment
Key elements of the model for coordinated and integrated physical and behavioral health services include:

- Ongoing communication and coordination, as clinically appropriate, between Primary Care providers (PCPs) and specialty providers, including behavioral health (mental health and substance use) providers.
- Screening by PCPs for behavioral health, substance use and co-occurring disorders.
- Screening by behavioral health provider for physical health conditions.
- Referrals to PCPs or specialty providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders and/or any known or suspected and untreated physical health disorders.
- Development of patient-centered treatment plans involving members as well as caregivers and family members when appropriate.
- Case management and disease management programs to support the coordination and integration of care between providers.
Fostering a culture of collaboration and cooperation helps sustain a seamless continuum of care between physical and behavioral health and positively impacts member outcomes. To maintain continuity of care, patient safety and member well-being, communication between behavioral health and physical care providers, as clinically appropriate, is critical, especially for members with comorbidities receiving pharmacological therapy.

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 Behavioral Health provider to determine medical necessity and will authorize out-of-network referrals on a limited basis. For assistance, contact the UM department: 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. Multi-lingual 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: www.UniCare.com. Click on 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: 1-800-782-0095
- To request interpreter services after hours, or TTY and Relay services, call MedCall®: 1-888-850-1108
- For TTY assistance during business hours, call UniCare’s Customer Care Center TTY line: 1-866-368-1634

Provider Roles and Responsibilities

Noncovered Services

All Behavioral Health providers must inform members of the costs associated with noncovered services prior to rendering the noncovered services. For more information, call our Customer Care Center: 1-800-782-0095. Also refer to the Private Pay Agreement section of Chapter 7: Claims and Billing.

Provider Roles and Responsibilities

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 Pre-Service 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 Pre-Service Review Decision
The Utilization Management Guidelines and the Hospital Agreement require that a hospital receive notice of a pre-service 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 pre-service review that has not received the appropriate review may be subject to post-service review denial. Generally, the provider is required to perform all pre-service review functions with UniCare. Before services are rendered, the hospital must ensure the pre-service review has been performed. If the pre-service review has not been performed, the hospital risks post-service denial.

Provider Roles and Responsibilities
Responsibilities Applicable to All Providers
The responsibilities 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
• Pre-Service Reviews
• Prohibited Activities
• Provider Contract Terminations
• Termination of Ancillary Provider/Patient Relationship
• Updating Provider Information

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 Chapter 5: Member Eligibility.

Provider Roles and Responsibilities

Behavioral Health 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.

Provider Roles and Responsibilities

Medical Records Standards

Medical records must be maintained in a manner ensuring effective and confidential member care and quality review. 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 provider of health care 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 security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and be in compliance.

Additional information on medical record storage, standards and security may be found in Chapter 15: Quality Assessment and Performance Improvement, beginning with the Medical Record Documentation Standards section.

Provider Roles and Responsibilities

Member Records and Treatment Planning: Comprehensive Assessment

Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews:

Information related to the provision of appropriate services to a member must be included in his or her record with documentation in a prominent place whether there is an executed declaration for behavioral health treatment.

Providers are expected to follow standard practice guidelines and to complete a comprehensive assessment that provides a description of the member’s physical and behavioral health status at the time of admission to services. Based upon commonly accepted best practices a comprehensive assessment includes the following domains and related elements:

- Psychiatric and psychosocial assessment including:
  - Description of the presenting problem
  - Psychiatric history and history of the member’s response to crisis situations
  - Psychiatric symptoms
o Multi-axial diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM)
  o Mental status exam

- **Medical assessment** including:
  o Screening for medical problems
  o Medical history
  o Present medications
  o Medication history

- **Substance use assessment** that includes:
  o Frequently used over-the-counter medications
  o Current and historical usage of alcohol and other drugs reflecting impact of substance use in the domains of the community functioning assessment
  o History of prior alcohol and drug treatment episodes and their effectiveness
  o History of alcohol and drug use

- **Community functioning assessment** or an assessment of the member’s functioning in the following domains:
  o Living arrangements, daily activities (vocational/educational)
  o Social support
  o Financial
  o Leisure/recreational
  o Physical health
  o Emotional/behavioral health
  o An assessment of the member’s strengths, current life status, personal goals and needs

**Provider Roles and Responsibilities**

**Member Records and Treatment Planning: Personalized Support and Care Plan**

A person-centered support and care plan based on the findings of current psychiatric, medical, substance use and community functioning assessments must be completed for any member who receives behavioral health services. There must be documentation in every case that the member and, as appropriate, his or her family members, caregivers or legal guardian, participated in the development and subsequent reviews of the treatment plan.

The initial support and care plan must be completed within the first 14 days of admission to behavioral health services and updated every 180 days, or more frequently as necessary based on the member’s progress toward goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.

**Member Records and Treatment Planning: Progress Notes**

Progress notes must document the status of the goals and objectives indicated on the treatment plans and should include:

- Correspondence concerning the member’s treatment and signed and dated notations of telephone calls concerning the member’s treatment
- Indication of active follow up actions for referrals given to the member and actions to fill gaps in care
- A brief discharge summary must be completed within 15 calendar days following discharge from services or death
- Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the member is receiving behavioral health services
Treatment and care plan and progress notes should be signed by the supervising practitioner - does not apply to Compressive Behavioral Health Centers (COMPs) and Licensed Behavioral Health Facilities (LBHCs)

Provider Roles and Responsibilities

Mandatory Reporting of Child Abuse, Elder Abuse or Domestic Violence

Providers must ensure that your office staff is familiar with local reporting requirements and procedures regarding telephone 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
  - 9-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

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. 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-Licensed Behavioral Health Practitioners

All providers using non-licensed behavioral health practitioners must provide supervision and oversight of these practitioners consistent with state and federal laws. The supervising practitioner must have written guidelines for adequate supervision. All supervising practitioners must follow state licensing and certification requirements.
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.

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: 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, or quality of care indicators.

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
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 pro-active 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

Behavioral Health Clinical Practice Guidelines

All providers have access to evidence-based clinical practice guidelines for a variety of behavioral health disorders commonly seen in primary care including attention deficit hyperactivity disorder, bipolar disorder for children and adults, major depressive disorder, schizophrenia and substance use disorders. These clinical practice guidelines are located online at:

http://www.UniCare.com > Other UniCare Websites > Providers > Resources for: State Sponsored Plan providers > West Virginia – Medicaid Managed Care
CHAPTER 14: CASE MANAGEMENT

Case Management Phone: 1-866-655-7423
Case Management Fax: 1-866-387-2959
Hours of Operation: Monday to Friday, 8 a.m.-6 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 on our website www.UniCare.com. Select the Caring For Diverse Populations 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.

Case Management Behavioral Health Case Management

UniCare’s behavioral health case management programs are designed to improve member health outcomes by integrating with our medical care programs and making reliable and proven protocols available to providers. UniCare’s case management is complimentary to and coordinates with any other case management services provided by a provider.

UniCare views case management as a continuum of services and supports that are matched on an individualized basis to the needs of the member. members who are identified as at-risk for hospitalization due to behavioral health or substance use disorders are offered ongoing case management support. In addition, members who are discharged from inpatient stays are provided case management support for a minimum of 180 days post discharge. UniCare’s case management services are primarily provided telephonically but can be field based in specific situations.

UniCare provides clinical teams staffed with West Virginia-based behavioral health and medical case managers working in close collaboration with community and provider-based case managers. The main functions of the UniCare behavioral health case managers include, but are not limited to:

- Use health risk assessment data gathered by UniCare from members to identify members who will benefit from engagement in individualized care coordination and case management.
- Use “trigger report data” based upon medical and behavioral health claims to identify members at risk.
- Consult and collaborate with our medical case managers and disease management clinicians regarding members who present with comorbid conditions.
Comorbid is either the presence of one or more disorders (or diseases) in addition to a primary disease or disorder, or the effect of such additional disorders or diseases.

- Refer members to provider-based case management, as clinically appropriate, for ongoing intensive case management and then continue involvement with the member and the provider to coordinate care, when needed, among different agencies, medical providers, etc.
- Work directly with the member and provider based upon the severity of the member’s condition.
- Document all actions taken and outcomes achieved for members in UniCare's information system to ensure accurate and complete reporting.

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 licensed social workers and licensed counselors, who add valuable skills that allow us to address our members’ medical needs, as well as psychological, social and financial issues.

Case Management

Behavioral Health Case Management Provider Responsibilities

Behavioral Health providers 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 provider 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.
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 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
- 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:
• Completing corrective action plans, when applicable
• 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

Quality Assessment and Performance Improvement

Avoiding an Adverse Decision

Most administrative adverse decisions result from non-adherence to, or a misunderstanding of, utilization management policies. Familiarizing yourself and your staff with notification and precertification policies and acting to meet those policies can eliminate the majority of these decisions. Other administrative adverse decisions result from misinformation about the member’s status or benefits. Such information is readily available from us by calling Customer Care at 1-800-782-0095.

Adverse decisions of a medical nature are rare. Such adverse decisions usually involve a failure of the clinical information to meet evidenced-based national guidelines. We are committed to working with all providers to ensure that such guidelines are understood and easily identifiable for providers. Peer-to-peer conversations (between a Medical Director and the provider clinicians) are one way to ensure the completeness and accuracy of the clinical information.

Medical record reviews are another way to ensure that clinical information is complete and accurate. Providers who can appropriately respond in a timely fashion to peer-peer and medical record requests are less likely to encounter dissatisfaction with the utilization management process. We are committed to ensuring a process that is quick and easy and will work with participating providers to ensure a mutually satisfying process.

Quality Assessment and Performance Improvement

Healthcare Effectiveness Data and Information Set (HEDIS)

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
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**

Twice a year, 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 Utilization Management Committee (UMC). 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. Local staff and 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: UniCare has 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. UniCare will make every effort to provide adequate notice when applicable. When circumstance warrant, no or limited notification will be given.

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 3 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 the Health Information Privacy and Accountability Act (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 7 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:
  - For patients 14 years old and older, the record must include information about substance abuse
  - 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
- 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

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 (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 re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please contact the Customer Care Center: **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 and Advanced Directive for Psychiatry, 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 on our website: [www.UniCare.com](http://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. For more information regarding Advance Directives, please visit the West Virginia Bureau for Behavioral Health and Health Facilities website at [https://dhhr.wv.gov/bhhf/Pages/default.aspx](https://dhhr.wv.gov/bhhf/Pages/default.aspx).

**Quality Assessment and Performance Improvement**

**Medical Record Review Process**

If a medical record review is deemed necessary, 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**

**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.
CHAPTER 16: 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.-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
pressure checks, etc. as long as the provider is not soliciting enrollment or distributing plan specific MCO materials.);

- 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;
- 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.

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: www.UniCare.com.
- UniCare sends each new member a New Member Kit within 1 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 identification (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.
CHAPTER 17: 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.-6 p.m.

Fraud, Abuse and Waste
Overview

We are committed to protecting the integrity of our health care program and the efficiency of our operations by preventing, detecting and investigating fraud, abuse and waste. This chapter provides a detailed explanation of fraud, abuse and waste, including examples and the steps for providers or members to report fraud, abuse and waste.

Fraud, Abuse and Waste
Understanding Fraud, Abuse and Waste

Combating fraud, abuse and waste begins with knowledge and awareness.

**Fraud:** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

**Abuse:** provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

**Waste:** Activities involving careless, poor or inefficient billing or treatment methods causing unnecessary expenses and/or mismanagement of resources.

Fraud, Abuse and Waste
Examples of Provider Fraud, Abuse and Waste

The following are examples of Provider fraud, abuse and waste:

- Altering medical records
- Billing for medically unnecessary tests
- Billing professional services performed by untrained personnel
- Billing for services not provided
- Misrepresentation of diagnosis or services
- Over-utilization or under-utilization
- Billing for services under another member’s identification (ID) card
- Double billing
- Soliciting, offering, or receiving kickbacks or bribes
- Unbundling
- Upcoding
Fraud, Abuse and Waste

Examples of Member Fraud, Abuse and Waste

The following are examples of member fraud, abuse and waste:

- Frequent emergency room visits for nonemergent conditions
- Forging, altering or selling prescriptions
- Allowing someone else to use a member’s UniCare ID card
- Lying about the amount of money or resources the member has for the purpose of obtaining benefits
- Lying about a medical condition to obtain medical treatment
- Obtaining controlled substances from multiple providers
- Relocating to an out-of-service area
- Using multiple providers to obtain similar treatments and/or medications
- Using a provider not approved by the primary care provider (PCP)
- Using someone else’s UniCare ID card

Fraud, Abuse and Waste

Reporting Provider or Member Fraud, Abuse or Waste

If you suspect either a provider (doctor, dentist, counselor, etc.) or member has committed fraud, abuse or waste, you have the right and responsibility to report the incident.

Provider Reporting

Providers may report allegations of fraud, abuse or waste by the following methods:

- Phone: 1-877-725-2702
- Complete and submit a Fraud Referral Form to UniCare:
  - Fax: 1-866-494-8279
  - Email: medicaidfraudinvestigations@anthem.com
  - Mail: Attn: Medicaid Special Investigations Unit
        UniCare Health Plan of West Virginia, Inc.
        4425 Corporation Lane, Mail Stop VA31
        Virginia Beach, VA 23462

To locate the Fraud Referral Form, go to www.UniCare.com > Provider Resources > Forms and Tools. 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.

Member Reporting

Members should let us know if they suspect a health care provider (such as a doctor, dentist or pharmacist) or another member, is doing something wrong. Members may report fraud, abuse or waste by the following methods:

- Phone: 1-877-725-2702
- TTY: 1-866-368-1634
- Mail: Attn: Medicaid Special Investigations Unit
        UniCare Health Plan of West Virginia, Inc.
        4425 Corporation Lane, Mail Stop VA31
        Virginia Beach, VA 23462

When reporting about a provider (a doctor, dentist, counselor, etc.), members should include:

- Name, address and telephone number of the provider
• Name and address of the facility (hospital, nursing home, home health agency, etc.)
• Medicaid number of the provider and facility, if available
• 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

When reporting about another member, the member should include:
• The person’s name
• The person’s date of birth, Social Security Number or case number, if this information is available
• The city where the person lives
• Specific details about the fraud, abuse or waste

Fraud, Abuse and Waste
Anonymous Reporting of Suspected Fraud, Abuse and Waste

Any incident of fraud, abuse or waste may be reported to us anonymously. However, we may not be able to pursue an investigation without additional information. In such cases, we will need the following:

• The name of person reporting and his/her relationship to the person suspected
• A call-back telephone number for the person reporting the incident

Please Note: The name of the person reporting the incident and the callback number will be kept in strict confidence by investigators to protect that person’s anonymity.

Fraud, Abuse and Waste
Investigation Process

UniCare does not tolerate acts adversely affecting providers or members. We investigate all reports of fraud, abuse and waste. If appropriate, allegations and the investigative findings are reported to the West Virginia Bureau for Medical Services (BMS), regulatory agencies and law enforcement agencies. In addition to reporting, we may take corrective action, such as:

• **Written warning and/or education:** We send certified letters to the provider or member 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 be reflected in reduced payment of future claims or further legal action.
Fraud, Abuse and Waste

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 has committed fraud, abuse or waste, the provider:

- Will be referred to the UniCare Quality Management department
- 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 has committed fraud or has failed to correct issues, the member may be involuntarily disenrolled from our health care plan, with state approval. Refer to Chapter 9: Member Transfers and Disenrollment for additional information.

Fraud, Abuse and Waste

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 3 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.

Fraud, Abuse and Waste

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 dollars (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, abuse, and waste.
- 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, abuse, and waste.
CHAPTER 18: 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. - 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 on 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.

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 Primary Care provider (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 doctor to set up treatment goals they agree on.
- Ask questions about any medical issue and make sure they understand what their doctor tells them.
- Follow the care plan and instructions that they have agreed on with their doctors or other health care professionals.
- Do the things that keep them from getting sick.
- Make and keep medical appointments and tell their doctor 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 doctor 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 19: 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.-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. Those challenges arise when providers need to cross a cultural divide to treat Members who may have different behaviors, attitudes and beliefs concerning health care. 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 awareness of cultural sensitivities 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 the 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: www.UniCare.com. Scroll to Health Education and click on 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

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.

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
- Common signs and sentences in many languages
- Language identification flashcards
- Language skill self-assessment tools

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

Identifies important legislation impacting cultural and linguistic services, including a summary of the Culturally and Linguistically Appropriate Services Standards (CLASS) 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: www.iceforhealth.org.

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 3 years for yourself. This language capability information will be reported in the Provider Directory to help members find a provider and/or office that can communicate in their preferred language.

Provide these updates using the Provider Change Form 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.
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: 1-800-782-0095. For after-hours interpreter services, call MedCall® 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 MedCall 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 MedCall Associate introduces the UniCare member, explains the reason for the call, and begins the dialogue.

For additional information on interpreter services, access the Health Education section of the Provider Resources page of our website: 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.
APPENDICES

- Appendix A: State Contacts

Appendix A - State of West Virginia Contacts

<table>
<thead>
<tr>
<th>If you have questions about...</th>
<th>WV Contact Information</th>
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</table>
| Bureau for Behavioral Health and Health Facilities | BHHF manages behavioral health services and is administered by the DHHR. Phone: **1-304-356-4811**  
Fax: **1-304-558-1008**  
Hours: Monday to Friday, 8:30am-4:30pm  
Website: [www.wvdhhr.org](http://www.wvdhhr.org) |
| Bureau for Children and Families (BCF) | Phone: **1-800-352-6513**  
Website: [www.wvdhhr.org/bcf](http://www.wvdhhr.org/bcf) |
| Bureau for Medical Services | BMS manages the Medicaid program for West Virginia is administered by the DHHR.  
Website: [www.dhr.wv.gov/bms](http://www.dhr.wv.gov/bms)  
Phone: **1-304-558-1700**  
Toll free Medicaid Provider Services: **1-888-483-0793**  
Address:  
Bureau for Medical Services  
Room 251  
350 Capitol St.  
Charleston, WV 25301 |
| Bureau for Public Health | Website: [www.dhr.wv.gov/bph](http://www.dhr.wv.gov/bph)  
Phone: **1-304-558-2971** |
<p>| Children with Disabilities Community Services Program | Phone: <strong>1-304-356-4904</strong> |</p>
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| **Commission for the Deaf and Hard of Hearing** | Phone: **1-304-558-1675**  
TTY (in West Virginia only) toll free: **1-866-461-3578**  
Fax: **1-304-558-0937**  
Website: [www.wvdhhr.org/wvcdhh](http://www.wvdhhr.org/wvcdhh)  
Address:  
Commission for the Deaf and Hard of Hearing  
405 Capitol St., Suite 800  
Charleston, WV 25301 |
| **Department of Health and Human Resources** | Phone: **1-304-558-0684**  
Fax: **1-304-558-1130**  
Website: [www.wvdhhr.org/](http://www.wvdhhr.org/)  
Address:  
Department of Health and Human Resources  
One Davis Square, Suite 100 East  
Charleston, WV 25301 |
| **Division of Rehabilitative Services (DRS)** | Website: [www.wvdrs.org](http://www.wvdrs.org) |
| **Enrollment** | In person: Visit your local Department of Health and Human Resources (DHHR) office. To locate your local office, go to:  
[www.wvdhhr.org/bcf/county](http://www.wvdhhr.org/bcf/county)  
Phone: Call the enrollment broker at **1-800-449-8466**  
Online: Visit [www.wvinroads.org](http://www.wvinroads.org) |
| **Grievances and Appeals: State Fair Hearing; Board of Review** | State fair hearing website: [www.wvdhhr.org/bcf](http://www.wvdhhr.org/bcf)  
Phone: **1-800-642-8589**  
| **Hearing or Speech Loss: West Virginia Relay Service** | West Virginia Relay Service is a toll free TDD service. Call **711** or the following numbers:  
- For voice to TDD, call: **1-800-982-8772**  
- For TDD to voice, call: **1-800-982-8771**  
Website: [www.westvirginiarelay.com](http://www.westvirginiarelay.com) |
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| **Home Health through BMS**   | Phone: **1-304-356-4840**  
Address:  
Bureau for Medical Services  
Program Manager, Home Health Services  
350 Capitol Street, Room 251  
Charleston, WV 25301 |
| **Hospice Services through BMS** | Phone: **1-304-356-4840**  
Address:  
Bureau for Medical Services  
Program Manager, Hospice Services  
350 Capitol St., Room 251  
Charleston, WV 25301 |
| **Office of Home and Community Based Services** | To contact, call BMS: **1-304-558-1700** |
| **Personal Care through BMS** | To contact, call BMS: **1-304-558-1700** |
| **Pharmacy Preferred Drug List (PDL)** | The PDL is available on the DHHR website: [www.wvdhhr.org](http://www.wvdhhr.org) |
| **Private Duty Nursing through BMS** | 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) |
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| West Virginia Women, Infants and Children (WIC) | Phone: 1-304-558-0030  
Fax: 1-304-558-1541  
Website: 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 |