Reimbursement Policy

March 2016

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member’s UniCare Health Plan of West Virginia, Inc. (UniCare) benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member’s state of residence. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, we strive to minimize these variations. For more information on these and other UniCare Reimbursement Policies, visit our website at www.unicare.com.

Policy Updates

Locum Tenens Physicians
(Policy 06-063, originally effective 03/01/2015)

UniCare allows reimbursement of locum tenens physicians in accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines. UniCare will reimburse the member’s regular physician or medical group for all covered services provided by a locum tenens physician during the absence of the regular physician in cases where the regular physician pays the locum tenens physician on a per diem or similar fee-for-time basis.

Please note, UniCare requires the regular physician or medical group to identify the locum tenens physician by entering their Unique Physician Identification Number (UPIN) or National Provider Identifier (NPI).

For additional information, refer to the Locum Tenens Physicians reimbursement policy at www.unicare.com.

Reimbursement for Reduced and Discontinued Services
(Policy 10-003, originally effective 03/01/2015)

UniCare allows reimbursement to professional providers and facilities for reduced or discontinued services when appended with the appropriate modifier. Modifiers 52, 53, 73 and 74 can be appended for reduced and discontinued services, if applicable.

Please note, Modifier 53 Indicates the physician elected to terminate a surgical or diagnostic procedure due to extenuating circumstances that threatened the well-being of the patient. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 53 is not applicable for facility billing, and is not valid when billed with E&M or time-based codes.

Modifier 73 indicates the physician cancelled the surgical or diagnostic procedure prior to administration of anesthesia and/or surgical preparation of the patient. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 73 is not applicable for professional provider billing.

www.unicare.com
For additional information and/or applicable modifier rules, refer to the Reimbursement for Reduced and Discontinued Services reimbursement policy at www.unicare.com.

Claims Submission – Required Information for Professional Providers
(Policy 06-029, originally effective 03/01/15)

Professional providers of health care services are required, unless otherwise stipulated in their contract, to submit an original Centers for Medicare & Medicaid Services (CMS)-1500 Health Insurance Claim Form to us for payment of health care services.

Providers must submit a properly completed CMS-1500 for services performed or items/devices provided. If the required information is not submitted, the claim is not considered a clean claim, and UniCare will deny payment without being liable for interest or penalties. The CMS-1500 claim form must include specific information, which follows CMS guidelines and is outlined in the reimbursement policy. UniCare cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return.

For additional information, refer to the Claims Submission – Required Information for Professional Providers reimbursement policy at www.unicare.com.

Claims Submission – Required Information for Facilities
(Policy 06-030, originally effective 03/01/2015)

Institutional providers (facilities) are required, unless otherwise stipulated in their contract, to submit the original Centers for Medicare & Medicaid Services UB-04/CMS-1450 Medicare Uniform Institutional Provider Bill to us for payment of health care services. Providers must submit a properly completed UB-04/CMS-1450 for services performed or items/devices provided. If the required information is not provided, the claim is not considered a clean claim and UniCare can delay or deny payment without being liable for interest or penalties. The UB-04/CMS-1450 claim form must include specific information, which follows CMS guidelines and is outlined in the reimbursement policy. UniCare cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return.

For additional information, refer to the Claims Submission – Required Information for Facilities reimbursement policy at www.unicare.com.

Documentation Standards for Episodes of Care
(Policy 11-004, originally effective 03/01/2015)

UniCare requires that documentation for all episodes of care must meet the following criteria:
- Documentation must be legible to someone other than the writer.
- Documentation must be complete, dated and timed.
- Documentation must reflect all aspects of care.
- Information identifying the member must be included on each page in the medical record.
- Each entry in the medical record must be dated and include author identification, which may be a handwritten signature, unique electronic identifier, or initials.

For a complete list of minimum documentation requirements, refer to the Documentation Standards of Episodes of Care reimbursement policy at www.unicare.com.

Your continued feedback is critical to our success. If you have questions, Medicaid providers can call 1-800-782-0095. You may also call your local UniCare representative.