Tobacco cessation counseling is a covered benefit for our members

This is a friendly reminder to primary care and obstetrics (OB) providers who service UniCare Health Plan of West Virginia, Inc. (UniCare) members, that tobacco cessation counseling is a covered benefit. For billing codes 99406 and 99407, there are no longer benefit limits. That means every time you examine a UniCare member, you can counsel them on tobacco cessation. This is especially important for our expectant mothers. For the claim to pay, the evaluation and management services must be billed with the appropriate modifier to indicate the additional service. Please note: If your practice is part of a federally qualified health center (FQHC) or a rural health clinic (RHC), tobacco cessation services are included in the encounter payment and will not pay separately.

Billing code information

- 99406: Smoking and tobacco cessation counseling visit - intermediate (greater than three minutes, up to 10 minutes)
- 99407: Smoking and tobacco cessation counseling visit - intensive (greater than 10 minutes)

Tobacco cessation counseling guide

Ask (one minute): Ask patient about his/her tobacco use; status should be documented in the medical record.

Advise (one minute): Provide clear, strong advice to quit with personalized messages about the impact of tobacco use.

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9. Facility Take Home DME and Medical Supplies
Assess (one to two minutes): Ask every tobacco user if they are willing to make an attempt to quit at this time. If they are not ready to quit, offer motivational intervention such as the “Five Rs”: relevance, risks, rewards, roadblocks and repetition.

Assist (five minutes or more): Suggest and encourage the use of problem-solving methods and skills for cessation:
- Refer to the West Virginia Tobacco Quit Line
- Arrange social support in the patient’s environment
- Give key advice on successful quitting techniques
- Set a quit date and help patient with the development of a quit plan
- Provide self-help smoking cessation materials
- Prescribe pharmacologic therapy as appropriate (nicotine replacement therapy and/or bupropion, if there are no contradictions)

Arrange (one minute or more): Schedule follow up either by office visit or telephone to periodically assess smoking status:
- Prevent relapse by congratulating successes and reinforcing reasons for quitting
- Assess any difficulties with pharmacologic therapy

West Virginia Tobacco Quit Line available to assist with tobacco cessation services
UniCare continues to provide our members with access to the West Virginia Tobacco Quit Line. If your patients are UniCare members and they are interested in tobacco cessation services, they should first meet for a counseling session and then be referred to the West Virginia Tobacco Quit Line at 1-877-966-8784. The West Virginia Tobacco Quit Line will triage callers, provide counseling services and assist members with obtaining nicotine replacement therapy. We have included a West Virginia Tobacco Quit Line fax referral form for your use.

UniCare pharmacotherapy benefit
Requests for a smoking cessation medication may be approved for individuals who meet the following criteria:
- Diagnosis of nicotine dependence and enrollment in a smoking cessation program
  - Confirmation of enrollment and ongoing participation in a smoking cessation program is required for approval and continued coverage
- Individual is 18 years of age or older
• Individual has had a trial of at least two of the following agents within the previous 120 days:
  o Bupropion
  o Nicotine gum
  o Nicotine patches
• Requests for Chantix (varenicline) to be used in combination with Zyban (bupropion SR) or nicotine replacement therapy will not be approved

<table>
<thead>
<tr>
<th>Preferred agents</th>
<th>Nonpreferred agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bupropion sr 150mg</td>
<td>Brand nicotine gums e.g., Nicorette</td>
</tr>
<tr>
<td>Generic nicotine gums</td>
<td>Brand nicotine lozenges e.g., Quit</td>
</tr>
<tr>
<td>Generic nicotine lozenges</td>
<td>Brand nicotine patches e.g., Nicoderm CQ</td>
</tr>
<tr>
<td>Generic nicotine patches</td>
<td>Chantix (varenicline)</td>
</tr>
<tr>
<td></td>
<td>Nicotrol inhaler (nicotine)</td>
</tr>
<tr>
<td></td>
<td>Nicotrol nasal spray (nicotine)</td>
</tr>
<tr>
<td></td>
<td>Zyban (bupropion SR)</td>
</tr>
</tbody>
</table>

**Routine cervical cancer screening**

We recently communicated with you regarding cervical cancer screening coverage for women younger than 21 years of age. This communication provides new coverage information about the frequency of cervical cancer screening for women at average risk. It does not address women with a history of prior abnormal results, precancerous cervical lesions, cervical cancer or those who are immunocompromised.

**Additional coverage information**

As previously communicated, routine screening pap testing will not be reimbursed for women younger than 21 years of age. In addition, effective October 30, 2016, routine screening frequency for women age 21 to 65 will be reimbursed no more frequently than once every three years. Also, reimbursement for routine pap testing for women 66 and older, with prior negative screening results, will be denied.

**Screening method and intervals**

The U.S. Preventive Services Task Force¹, the American College of Obstetricians and Gynecologists², the American Cancer Society³, the American Society for Colposcopy and Cervical Pathology and the American Society for Clinical Pathology all agree that the optimal screening interval is not more frequently than every three years.
<table>
<thead>
<tr>
<th>Population</th>
<th>Recommended screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women younger than 21 years</td>
<td>No screening</td>
</tr>
<tr>
<td>Women aged 21-29 years</td>
<td>Cervical pap alone every three years</td>
</tr>
<tr>
<td>Women aged 30-65 years</td>
<td>Human papillomavirus (HPV) and cervical pap co-testing every five years or cervical pap alone every three years</td>
</tr>
<tr>
<td>Women older than 65 years</td>
<td>No screening is necessary after adequate negative prior screening results</td>
</tr>
<tr>
<td>Women who underwent total hysterectomy (with no residual cervix).</td>
<td>No screening is necessary</td>
</tr>
</tbody>
</table>

We encourage you to adopt this medical society and industry recommendation in the interest of improving patient quality and reducing harm from unnecessary follow up.


**New fax numbers for UniCare Health Plan of West Virginia, Inc. Utilization Management**

Effective May 1, 2016, two new fax numbers will be available to submit authorization requests to UniCare Health Plan of West Virginia, Inc. (UniCare).

- Prior authorization request: **1-855-402-6983**
- Continued stay review for clinical request: **1-855-402-6985**

You may continue to request prior authorizations, report a medical admission or ask questions regarding prior authorizations by calling UniCare’s Utilization Management department at **1-866-655-7423**.
New requirements for credentialing and certification effective July 1, 2016

Effective July 1, 2016, we will require credentialing for several additional practitioner and health delivery organization (HDO) provider types when those providers are contracted by UniCare Health Plan of West Virginia, Inc. (UniCare). Credentialing involves verification of basic professional conduct and competency criteria including licensure, education and training, and sanction activity. Each provider’s application will be reviewed by a local credentialing committee or medical director for approval; recredentialing will occur every three years thereafter.

We will apply these new credentialing requirements to new providers effective July 1, 2016, and a rollout plan to credential existing participating providers will begin in July 2016.

Following are the new practitioner and HDO provider types that will require credentialing effective July 1, 2016:

**Practitioner provider types:***
- Licensed genetic counselors
- Audiologists
- Acupuncturists (non-medical doctors [MD] or doctors of osteopathic medicine [DO])
- Nurse practitioners, certified nurse midwives and physician assistants
- Registered dieticians

**Credentialing will be required for the above practitioners when they are:**
- Contracted independently
- Contracted at a group practice level and are listed in our directories
- Licensed by the state to practice independently

**HDO provider types:**
- Behavioral health facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings:
  - Adult family care/foster care homes
  - Ambulatory detox
  - Community mental health centers (CMHC)
  - Crisis stabilization units
  - Intensive family intervention services
  - Intensive outpatient – mental health and/or substance abuse
  - Methadone maintenance clinics
 Credentialing will be required for the above HDOs when they are contracted independently by us today or are listed in our directories. (Note that the updated Provider Manual will have a list of HDO types and the corresponding accrediting agencies approved by UniCare.)

How to get started
Based on your provider type, you will either use the Council for Affordable Quality Healthcare’s (CAQH) ProView online service or complete and return an HDO application along with required attachments, as explained below.*

If contracted today, independently or listed in our directories, the following providers must use CAQH’s ProView.
- Licensed genetic counselors
- Audiologists
- Acupuncturists (non-MDs or DOs)
- Nurse practitioners, certified nurse midwives and physician assistants

ProView is a free, online service that allows health care providers to fill out one application to meet the credentialing data needs of multiple organizations. ProView allows health care providers to:
- Complete and attest to multiple state credentialing applications in one workflow design
- Upload supporting documents directly into ProView to eliminate the need for manual submission and to improve the timeliness of completed applications
- Review and approve practice manager information
- Self-register with the system before a health plan initiates the application process
If you are already using CAQH, please keep your application updated so there is no delay in the credentialing process and your provider directory listing. We will take care of adding you to our CAQH Roster. If you don’t currently use CAQH’s Global Authorization, please be sure to authorize UniCare to view your credentials.

If you don’t currently use CAQH, you may self-register with CAQH at www.caqh.org. For questions about CAQH ProView, please contact the CAQH ProView Support Desk:

- **Email**: providerhelp@ProView.CAQH.org
- **Phone**: 1-888-599-1771

*HDO and facility providers will not use the practitioner CAQH ProView application process referenced above. These providers should complete the Health Delivery Organization/Facility Application which is located at anthem.com > Providers > State > Answers@Anthem > Forms.

**Certification process**

In addition to the change in the provider scope for credentialing, we will begin to verify certifications and licensure, as applicable, for the following provider types when contracted as part of a certification review process:

- Certified behavioral analysts
- Certified addiction counselor
- Substance abuse practitioners
- Clinical laboratories
- End stage renal disease (ESRD) service providers (dialysis facilities)
- Portable X-ray suppliers

The certification process will include a review of licensure or certifications, such as Medicare or Clinical Laboratory Improvement Amendments (CLIA), and a review of any federal sanctions.

The Credentialing team looks forward to working with you. If you have any questions, please contact JoEllen Scheid at JoEllen.Scheid@anthem.com.
**Availity – Register today!**

Recently, Unicare introduced the Availity Web Portal, a tool to help reduce costs and reduce administrative burden for our physicians and hospitals. Whether you work with one managed care organization (MCO) or hundreds, you can quickly and easily file claims, check eligibility and claim status and more using the Availity Web Portal.

It’s time to register for the Availity Web Portal! Go to [www.availity.com](http://www.availity.com) (make a link) to register today. If you already use Availity, no additional registration is needed. Unicare will appear as one of your options in the payer dropdown menus.

**What is the Availity Web Portal and who can use it?**

Health care providers in our network can use the secure Web-based portal too quickly and easily:

- Get current patient insurance coverage information (including eligibility and benefits)
- Submit medical claims online
- Monitor the status of claims submissions
- View reports including panel listings
- Link back to the Unicare AccessPoint website for any remaining transactions, including precertification requests and appeals. A direct link to the provider self-service website is accessible on the My Payer Portal in the left-hand navigation bar on the Availity website once Unicare Services Registration is completed by your administrator.

If you experience any difficulties, contact Availity Client Services at 1-800-Availity (1-800-282-4548).

**How do I register with Availity?**

Registration is easy; go to www.availity.com and choose the green Get Started button under Register now for the Availity Web Portal. Select Start Registration. You will be asked to complete the following steps to confirm your registration:

<table>
<thead>
<tr>
<th>STEP 1: Tell Us About Yourself</th>
<th>You will be asked about yourself to determine if you already have a user account. If no account exists, you need to create one.</th>
</tr>
</thead>
</table>
| STEP 2: Tell Us About Your Organization | 1. Select your organization type (provider, billing service, technology company or MCO).  
2. Enter your organization name.  
3. Enter your tax identification number.  
4. Enter your organization’s National Provider ID.  
5. Select your provider type (e.g., physician practice, hospital, multi-physician practice).  
6. Click Next. |
### STEP 3: Select Your Organization
(This screen displays if details on your organization exist.)

The **Your Organization Information Page** will prepopulate based on information previously entered.

If you don’t see your practice or specific practice location, click **I don’t see my organization.**

### STEP 4: Your Organization Information

1. Review your information, edit any incorrect fields and enter any missing information.
2. If your organization operates in more than one state, check the box **My Organization Does Business in More Than One Region.** Availity automatically assigns your organization access to payers in your physical address state.
3. Click **Next.**

### STEP 5: Select Your Administrator/s

In this section you must identify the person that will be responsible for the following roles:

- **Administrator:** The person who is responsible for maintaining users and organization information and has the authority to sign documents.
- **Back-up Administrator:** The person who can serve as a secondary admin (although this is optional, we encourage the designation of a Back-up Administrator)

### STEP 6: To complete your registration

1. Review all the information entered and edit, if necessary.
2. Select **Submit Registration** and the Administrator will received an email within one business day confirming registration.

### STEP 7: Next Steps:

1. Your designated Administrator must sign in to Availity within 14 calendar days from receipt of the email.
2. The administrator can then register additional users by selecting **Add Users** from the **Admin Dashboard** landing page.

For questions or additional registration assistance, contact Availity Client Services Monday through Friday, 8 a.m. to 7 p.m. Eastern time at **1-800-Availity (1-800-282-4548)**. Please have your application ID available when calling.
Reimbursement Policies

New Policy
Medical Recalls
(Policy 06-111, effective 10/01/2016)

UniCare Health Plan of West Virginia, Inc. (UniCare) does not allow reimbursement for repair or replacement of items due to a medical recall. The following are applicable items:

- Durable medical equipment
- Supplies
- Prosthetics
- Orthotics
- Drugs/vaccines

UniCare will allow reimbursement of medically necessary procedures to remove and replace recalled or replaced devices. UniCare will not be responsible for the full cost of a replaced device if an inpatient or outpatient facility is receiving a partial or full credit for a device due to recall. Payment will be reduced by the amount of the device credit.

For additional information, refer to the Medical Recalls reimbursement policy at www.unicare.com.

New Policy
Multiple Procedure Payment Reduction
(Policy 15-002, effective 10/01/2016)

We allow reimbursement for multiple procedures unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

When services are performed on the same date of service during the same patient encounter, and are performed by the same physician or health care professional with the same National Provider Identifier (NPI) or multiple providers in the same group practice with the same group NPI, the following will be subject to Multiple Procedure Payment Reductions (MPPR):

- “Always therapy” services
- Cardiovascular procedures
- Ophthalmology procedures

For additional information regarding reimbursement for these services and procedures, refer to the Multiple Procedure Payment Reduction policy at www.unicare.com.
Policy Updates
Modifier 77: Repeat Procedure by another Physician or other Qualified Health Care Professional
(Policy 06-019, effective 08/15/2016)

We allow reimbursement for applicable procedure codes appended with Modifier 77 to indicate a procedure or service was repeated by another physician.

Unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise, reimbursement is based on the following use of Modifier 77:

- For a nonsurgical procedure or service: 100 percent of the applicable fee schedule or contracted/negotiated rate
- For a surgical procedure: 100 percent of the applicable fee schedule or contracted/negotiated rate for the surgical component only limited to a total of two surgical procedures

Professional services, other than radiology which are excluded from this requirement, will be subject to clinical review for consideration of reimbursement. Providers must submit supporting documentation for the use of Modifier 77 with the claim. If a claim is submitted with Modifier 77 without supporting documentation, the claim will be denied. Providers will be asked to submit the required documentation for reconsideration of reimbursement. Failure to use Modifier 77 when appropriate may result in denial of the procedure or service.

For additional information, refer to the Modifier 77 reimbursement policy at www.unicare.com.

Policy Reminder
Facility Take Home DME and Medical Supplies
(Policy 06-081, originally effective 03/01/2015)

UniCare Health Plan of West Virginia, Inc. (UniCare) does not allow reimbursement of Durable Medical Equipment (DME) and medical supplies dispensed by a facility for take-home use under the inpatient or outpatient hospital benefit. Facility claims submitted for DME and medical supplies billed with revenue codes denoting take-home use will be denied.

To be considered for reimbursement, claims for take-home DME and medical supplies should be submitted by a DME/supply vendor. Reimbursement is based on the:

- Contract or negotiated rate for participating vendors
- Out-of-network fee schedule or negotiated rate for non-participating vendors
UniCare allows reimbursement of facility claims for medical supplies dispensed to the member at discharge and billed with revenue codes other than take-home for the following items:

- Crutches
- No more than 72 hours of medical supplies if the provider was not able to obtain supplies from a vendor by discharge

For additional information, refer to the Facility Take Home DME and Medical Supplies reimbursement policy at [www.unicare.com](http://www.unicare.com).