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CHAPTER 1: INTRODUCTION

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

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

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

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

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

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

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

- Legal Requirements
- Contact Numbers
- Before Rendering Services
- After Rendering Services
- Operational Standards, Requirements and Guidelines
- Additional Resources
**The Availity Portal**
The Availity Portal offers health care professionals free access to real-time information and instant responses in a consistent format regardless of the payer.

Through the Availity Portal, you can:
- Confirm eligibility.
- Determine if a prior authorization is required.
- Request authorizations.
- Submit claims.
- View the status of a claim.
- Dispute a claim.
- Submit a medical attachment.

For more information in using Availity, see [Availity Tips](#).

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

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

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

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

**After Rendering Services**
At UniCare, our goal is to make the billing process as streamlined as possible. The After Rendering Services section provides guidelines and detailed coding charts for fast, secure and efficient billing and includes specific information about filing claims for professional and institutional services. In addition, the Member Transfers chapter outlines the steps for members who want to change their assignment of PCP or transfer to another health plan. When questions or concerns come up about claims or adverse determinations, our chapter on grievances and appeals will take you step-by-step through the process.
Operational Standards, Requirements and Guidelines
This section summarizes the requirements for provider office operations and access standards, thereby ensuring consistency when members need to consult with providers for IHAs, referrals, coordination of care and follow-up care. Additional chapters detail provider credentialing, provider roles and responsibilities, and enrollment and marketing guidelines. Chapters on both clinical practice and preventive health guidelines and case management outline the steps providers should take to coordinate care and help members take a proactive stance in the fight against disease. And finally, we included a chapter documenting our commitment to participate in the quality assessments that help UniCare measure, compare and improve our standards of care.

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

Accessing Information, Forms and Tools on Our Website
A wide array of tools, information and forms are accessible via our provider website at www.unicare.com. Throughout this manual, we will refer you to items located on provider website. To access this page, please follow these steps:
1. Select Medicaid at the top of the screen.
2. Select Providers on the right side of the screen.
3. Select the topic tab of interest, including Resources, Claims, Patient Care, Pharmacy or Communications.

To access a PDF of this provider manual online, select the Resources tab and select Provider Manual

Helpful tip: https://provider.unicare.com is a direct connect to provider resources and communications

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

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

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

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

Privacy Practices
UniCare’s latest HIPAA-compliant privacy and security statements may be found in the Notice of Privacy Practices. For more information, refer to the provider website at www.unicare.com. For directions on how to access 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.

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

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

In the event of a material change to the 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.

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

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

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):
• Through the OCR complaint portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.
• By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201.
• By phone at: 1-800-368-1019 (TTY/TTD: 1-800-537-7697).

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

UniCare provides free tools and services to people with disabilities to communicate effectively with us. UniCare also provides free language services to people whose primary language isn’t English (for example, qualified interpreters and information written in other languages). These services can be obtained by calling the Member Services number on their member ID card.

If you or your patient believe that UniCare has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with our member advocate via:
• Phone: 1-888-611-9958
• Mail: 200 Association Drive, Suite 200, Charleston, WV 25311
Equal Program Access on the Basis of Gender

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

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

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

UniCare Contacts

<table>
<thead>
<tr>
<th>Contact Information for UniCare</th>
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<tbody>
<tr>
<td><strong>If you have questions about...</strong></td>
</tr>
<tr>
<td><strong>Address</strong></td>
</tr>
<tr>
<td><strong>Note:</strong> For faster service, please indicate how you want the correspondence routed (for example, “Attn: Initial Claims Department”).</td>
</tr>
<tr>
<td><strong>Authorization</strong></td>
</tr>
<tr>
<td><strong>Availity</strong></td>
</tr>
<tr>
<td><strong>Benefits, eligibility, verifying PCP and general provider questions</strong></td>
</tr>
<tr>
<td><strong>Case Management referrals</strong></td>
</tr>
<tr>
<td>If you have questions about . . .</td>
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<tr>
<td>----------------------------------</td>
</tr>
</tbody>
</table>
| Claims overpayment | Mail overpayment to:  
UniCare Health Plan of West Virginia, Inc.  
Attn: Overpayment Recovery  
P.O. Box 73651  
Cleveland, OH 44193  
Address for overnight delivery:  
UniCare Health Plan of West Virginia, Inc.  
Attn: Overpayment Recovery  
Lockbox 92420  
4100 West 150th St.  
Cleveland, OH 44135 |
| Customer Care Center | Hours: Monday to Friday, 8 a.m. to 6 p.m.  
Phone: **1-800-782-0095**  
- For voice to TDD: **1-800-982-8772**  
- For TDD to voice: **1-800-982-8771**  
Fax: **1-888-438-5209**  
After hours:  
Phone: **1-888-850-1108**  
TTY: **1-800-368-4424** |
| Dental services: Scion Dental | Member Information:  
Phone: **1-877-408-0917**  
TTY: **1-800-508-6975**  
Hours: 8 a.m. to 6 p.m.  
Website: [www.skygenusa.com](http://www.skygenusa.com)  
Provider Hotline:  
Phone: **1-877-724-6602**  
Adult emergent: **1-877-408-0881**  
Children Medicaid: **1-888-983-4686**  
Hours: Monday to Friday, 8 a.m. to 6 p.m. |
| Fraud and abuse | **Fraud Hotline**  
Phone: **1-877-660-7890 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 |
| 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. |
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<tr>
<th>If you have questions about . . .</th>
<th>Contact:</th>
</tr>
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</table>
| Grievances and appeals (cont.)   | 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 the 24/7 NurseLine: **1-888-850-1108**  
For TTY and relay services during business hours, call UniCare’s Customer Care Center TTY line:  
- For voice to TDD: **1-800-982-8772**  
- For TDD to voice: **1-800-982-8771**  
After hours, call the 24/7 NurseLine TTY line: **1-800-368-4424** |
| UniCare office                  | To obtain UniCare staff contact information, contact your network education representative:  
- Phone: **1-888-611-9958**  
- Fax: **1-888-338-1320**  
Address:  
UniCare Health Plan of West Virginia, Inc.  
200 Association Drive, Suite 200  
Charleston, WV 25311 |
| 24/7 NurseLine                  | Phone: **1-888-850-1108**  
TTY: **1-800-368-4424**  
Hours: 24/7  
Available after normal business hours to verify member eligibility. |
| Members with hearing or speech loss | West Virginia Relay Service is a toll-free TDD service. Call **711** or the following numbers:  
- For voice to TDD: **1-800-982-8772**  
- For TDD to voice: **1-800-982-8771**  
Website: [www.westvirginiarelay.com](http://www.westvirginiarelay.com) |
| Pharmacy help desk (Molina Healthcare*) | Prescriber prior authorization:  
- Phone: **1-888-483-0801**  
- Fax: **1-800-531-7787** |
| Pharmacy Preferred Drug List (PDL) inquiries | The PDL is part of the pharmacy service provided by BMS and is located on the BMS website at [www.dhhr.wv.gov/bms](http://www.dhhr.wv.gov/bms). In the Providers section, select Pharmacy. In the top navigation menu, select Preferred Drug List. Scroll to select the most recently posted version. |
| Physician-administered drugs (preauthorization) | Phone: **1-877-375-6185**  
Fax: **1-844-487-9290** |
If you have questions about... | Contact:
--- | ---
Smoking Cessation Program | For questions regarding this program, call the Customer Care Center: Phone: **1-800-782-0095**  
TTY: **1-866-368-1634**  
Hours: Monday to Friday, 8 a.m. to 6 p.m.  
Materials available for download:  
- The “Quit Guide” Clearing the Air is available at the website: smokefree.gov  
- National Cancer Institute phone (for ordering): **1-800-4-CANCER** (1-800-422-6237). Website: [https://pubs.cancer.gov](https://pubs.cancer.gov)

Vision Services - Vision Service Plan (VSP) | Website: [www.vsp.com](http://www.vsp.com)  
Contact information for members:  
Phone: **1-800-877-7195**  
TTY: **1-800-428-4833**  
Hours: Monday to Friday, 8 a.m. to 11 p.m.; Saturday, 10 a.m. to 7 p.m.  
Contact information for providers (claims and membership questions):  
Phone: **1-800-615-1883**  
Hours: Monday to Friday, 8 a.m. to 11 p.m.; Saturday, 10 a.m. to 7 p.m.  
Email: questions@vspglobal.com

**State of West Virginia Contacts**

<table>
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<th>Contact Information for the State of West Virginia</th>
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<td>If you have questions about...</td>
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</tbody>
</table>
| Breastfeeding support | Breastfeeding Education Coordinator, Office of Nutrition Services  
Phone: **1-304-558-0030**  
Website: [https://www.wvdhhr.org/ons/breastfeeding.asp](https://www.wvdhhr.org/ons/breastfeeding.asp) |
| Bureau for Behavioral Health (BHH) | BHH manages behavioral health services and is administered by the DHHR.  
Phone: **1-304-356-4811**  
Fax: **1-304-558-1008**  
Hours: Monday to Friday, 8:30 a.m. to 4:30 p.m.  
Website: [https://dhhr.wv.gov/bhhf](https://dhhr.wv.gov/bhhf) |
| Bureau for Children and Families (BCF) | Phone: **1-304-558-0628**  
Fax: **1-304-558-4194**  
Website: [https://dhhr.wv.gov/bcf](https://dhhr.wv.gov/bcf) |
| Bureau for Medical Services | BMS manages the Medicaid program for West Virginia, administered by the DHHR.  
Website: [www.dhhr.wv.gov/bms](http://www.dhhr.wv.gov/bms)  
Phone: **1-304-558-1700**  
Toll-free Medicaid Provider Services: **1-888-483-0793**  
Address:  
Bureau for Medical Services  
350 Capitol St., Room 251  
Charleston, WV 25301 |
<table>
<thead>
<tr>
<th>If you have questions about...</th>
<th>Contact:</th>
</tr>
</thead>
</table>
| Bureau for Public Health       | Website: [www.dhhr.wv.gov/bph](https://www.dhhr.wv.gov/bph)  
Phone: **1-304-558-2971** |
| Children with Disabilities    | Website: [www.dhhr.wv.gov/bms/Programs/Pages/default.aspx](https://www.dhhr.wv.gov/bms/Programs/Pages/default.aspx)  
Phone: **1-304-356-4904** |
| Community Services Program    | Phone: **1-304-558-1675**  
TTY (in West Virginia only) toll free: **1-866-461-3578**  
Fax: **1-304-558-0937**  
Website: [https://www.wvdhhr.org/wvcdhh](https://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: [https://dhhr.wv.gov/Pages/default.aspx](https://dhhr.wv.gov/Pages/default.aspx)  
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](https://www.wvdrs.org) |
| Enrollment                     | In person: Visit your local Department of Health and Human Resources (DHHR) office. To locate your local office, go to: [https://dhhr.wv.gov/bcf/Documents/DHHR.BCF.LocalOffices.pdf](https://dhhr.wv.gov/bcf/Documents/DHHR.BCF.LocalOffices.pdf)  
Phone: Call the enrollment broker at **1-800-449-8466**.  
Website: [www.wvinroads.org](https://www.wvinroads.org) |
| Grievances and appeals: state fair hearing; board of review | State fair hearings website: [https://dhhr.wv.gov/bcf](https://dhhr.wv.gov/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: **1-800-982-8772**  
• For TDD to voice: **1-800-982-8771**  
Website: [www.westvirginirelay.com](https://www.westvirginirelay.com) |
| Home health through BMS        | Website: [www.dhhr.wv.gov/bms/Programs/Pages/default.aspx](https://www.dhhr.wv.gov/bms/Programs/Pages/default.aspx)  
Phone: **1-304-356-4840**  
Address: Bureau for Medical Services  
Program Manager, Home Health Services  
350 Capitol St., Room 251  
Charleston, WV 25301 |
<table>
<thead>
<tr>
<th>If you have questions about...</th>
<th>Contact:</th>
</tr>
</thead>
</table>
| Hospice services through BMS | Website: [www.dhhr.wv.gov/bms/Programs/Pages/default.aspx](http://www.dhhr.wv.gov/bms/Programs/Pages/default.aspx)  
Phone: **1-304-356-4840**  
Address:  
Bureau for Medical Services  
Program Manager, Hospice Services  
350 Capitol St., Room 251  
Charleston, WV 25301 |
| Office of Home and Community Based Services | Website: [www.dhhr.wv.gov/bms/Programs/Pages/default.aspx](http://www.dhhr.wv.gov/bms/Programs/Pages/default.aspx)  
To contact, call BMS: **1-304-356-4904** |
| Personal care through BMS | Website: [www.dhhr.wv.gov/bms/Programs/Pages/default.aspx](http://www.dhhr.wv.gov/bms/Programs/Pages/default.aspx)  
To contact, call BMS: **1-304-558-1700** |
| Private duty nursing through BMS | Website: [www.dhhr.wv.gov/bms/Programs/Pages/default.aspx](http://www.dhhr.wv.gov/bms/Programs/Pages/default.aspx)  
Phone: **1-304-356-4840**  
Address:  
Program Manager, Private Duty Nursing Services  
Bureau for Medical Services  
350 Capitol St., Room 251  
Charleston, WV 25301 |
| West Virginia HealthCheck through Early and Periodic Screening, Diagnosis and Treatment (EPSDT) | Phone: **1-800-642-9704**  
Website: [www.dhhr.wv.gov/healthcheck](http://www.dhhr.wv.gov/healthcheck) |
| West Virginia Women, Infants and Children (WIC) | Phone: **1-304-558-0030**  
Fax: **1-304-558-1541**  
Website: [http://ons.wvdhhr.org](http://ons.wvdhhr.org)  
Email: dhhrwic@wv.gov  
Address:  
Office of Nutrition Services  
West Virginia WIC Program  
350 Capitol St., Room 519  
Charleston, WV 25301-3715 |
CHAPTER 4: COVERED AND NONCOVERED SERVICES

UniCare

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

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

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

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

UniCare Covered Services

Covered services include, but are not limited to:

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

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

Coverage and authorization requirements can also be viewed using the Precertification Look Up Tool at https://providers.amerigroup.com/unicare/Pages/precertification-lookup.aspx.

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

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

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

**Mountain Health Trust Benefits Summary**

<table>
<thead>
<tr>
<th>Children (0 to 20 years )</th>
<th>Adults (21 years and older)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance (emergency only)</td>
<td>Ambulance (emergency only)</td>
</tr>
<tr>
<td>Ambulatory surgical center services</td>
<td>Ambulatory surgical center services</td>
</tr>
<tr>
<td>Behavioral health rehabilitation</td>
<td>Substance Use Disorder Residential Adult Services</td>
</tr>
<tr>
<td>• Residential treatment</td>
<td>• Residential treatment – Ages 18 and older</td>
</tr>
<tr>
<td>Cardiac and pulmonary rehabilitation</td>
<td>Cardiac and pulmonary rehabilitation</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Chiropractic services</td>
</tr>
<tr>
<td>Dental services:</td>
<td>Dental services (emergency treatment)</td>
</tr>
<tr>
<td>• Orthodontics</td>
<td></td>
</tr>
</tbody>
</table>

- 23 -
<table>
<thead>
<tr>
<th>Children (0 to 20 years)</th>
<th>Adults (21 years and older)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes management</td>
<td>Diabetes management</td>
</tr>
<tr>
<td>Durable medical equipment:</td>
<td>Durable medical equipment:</td>
</tr>
<tr>
<td>• Orthotics and prosthetics</td>
<td>• Orthotics and prosthetics</td>
</tr>
<tr>
<td>EPSDT (Well-child visits)</td>
<td>Family planning services and supplies</td>
</tr>
<tr>
<td>• Right From the Start Services</td>
<td>• Right From the Start Services</td>
</tr>
<tr>
<td>Hearing services</td>
<td>Hearing services</td>
</tr>
<tr>
<td>Home health including skilled nursing</td>
<td>Home health including skilled nursing</td>
</tr>
<tr>
<td>Hospice</td>
<td>Hospice</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>Inpatient services</td>
</tr>
<tr>
<td>• Inpatient hospital care</td>
<td>• Inpatient hospital care</td>
</tr>
<tr>
<td>• Inpatient rehabilitation</td>
<td>• Inpatient rehabilitation</td>
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<tr>
<td>• Inpatient behavioral health and substance use disorder services</td>
<td>• Inpatient behavioral health and substance use disorder services</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>Outpatient services</td>
</tr>
<tr>
<td>• Behavioral health</td>
<td>• Behavioral health</td>
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<tr>
<td>• Chiropractic services</td>
<td>• Chiropractic services</td>
</tr>
<tr>
<td>• Diagnostic X-ray, laboratory services and testing</td>
<td>• Diagnostic X-ray, laboratory services and testing</td>
</tr>
<tr>
<td>• Occupational therapy</td>
<td>• Occupational therapy</td>
</tr>
<tr>
<td>• Physical therapy</td>
<td>• Physical therapy</td>
</tr>
<tr>
<td>• Speech therapy</td>
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</tr>
</tbody>
</table>

**Physical; Speech and Occupational Therapy:**
- Participating providers may render up to 20 therapy visits to an eligible Mountain Health Trust member without prior authorization. Beginning with the 21st visit, prior authorization is required to continue treatment. The limit excludes evaluation and re-evaluation and occurs over a 12-month rolling period. A visit may include any combination of physical/occupational therapy procedures.

**Chiropractic Services:**
- Participating providers may render up to 24 visits to an eligible Mountain Health Trust member without prior authorization. Beginning with the 25th visit, prior authorization is required to continue treatment.
<table>
<thead>
<tr>
<th>Children (0 to 20 years )</th>
<th>Adults (21 years and older)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/nurse practitioner (NP)/nurse midwife (NMW)/federally qualified health center (FQHC)/rural health center (RHC) services:</td>
<td>Physician/PA/NP/NMW/FQHC/RHC services:</td>
</tr>
<tr>
<td>• Primary/preventive care visits</td>
<td>• Primary/preventive care visits</td>
</tr>
<tr>
<td>• Physician office visits</td>
<td>• Physician office visits</td>
</tr>
<tr>
<td>• Specialty care</td>
<td>• Specialty care</td>
</tr>
<tr>
<td>• Podiatry</td>
<td>• Podiatry</td>
</tr>
<tr>
<td>Private duty nursing</td>
<td>Provider-administered medications</td>
</tr>
<tr>
<td>Provider-administered medications</td>
<td>Psychological Services</td>
</tr>
<tr>
<td>Psychological Services</td>
<td></td>
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<tr>
<td>Vision</td>
<td></td>
</tr>
</tbody>
</table>

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

| Outpatient pharmacy medications | Outpatient pharmacy medications |
| Nonemergency transportation | Nonemergency transportation |
| Nursing home services | Nursing home services |
| Abortion | Abortion |
| Hemophilia factors | Hemophilia factors |
| Hepatitis drugs | Hepatitis drugs |
| Personal care services | Personal care services |
| School-based services | |
| Transplants (except corneal transplants, which are covered by UniCare) | Transplants (except corneal transplants, which are covered by UniCare) |

**West Virginia Health Bridge Benefit Summary**

<table>
<thead>
<tr>
<th>Children (Age 19 to 20 years )</th>
<th>Adults (21 years and older)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance (emergency only)</td>
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</tr>
<tr>
<td>Ambulatory surgical center services</td>
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</tr>
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<td>Cardiac and pulmonary rehabilitation</td>
<td>Cardiac and pulmonary rehabilitation</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Chiropractic services</td>
</tr>
<tr>
<td>Dental services</td>
<td>Dental services (emergency treatment)</td>
</tr>
<tr>
<td>Diabetes management</td>
<td>Diabetes management</td>
</tr>
<tr>
<td>Durable medical equipment</td>
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</tr>
<tr>
<td>• Orthotics and prosthetics</td>
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<td>Family planning services and supplies</td>
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<td>Hearing services</td>
<td></td>
</tr>
<tr>
<td>Home health including skilled nursing</td>
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</tr>
<tr>
<td>Hospice</td>
<td>Hospice</td>
</tr>
<tr>
<td>Children (Age 19 to 20 years)</td>
<td>Adults (21 years and older)</td>
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<tr>
<td>--------------------------------</td>
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</tr>
<tr>
<td>Inpatient services</td>
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</tr>
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<tr>
<td>- Occupational therapy</td>
<td>- Occupational therapy</td>
</tr>
<tr>
<td>- Physical therapy</td>
<td>- Physical therapy</td>
</tr>
<tr>
<td>- Speech therapy</td>
<td>- Speech therapy</td>
</tr>
</tbody>
</table>

**Physical; Speech and Occupational Therapy:**
Participating providers may render up to 30 therapy visits to an eligible West Virginia Health Bridge member without prior authorization. Beginning with the 31st visit, prior authorization is required to continue treatment. The limit excludes evaluation and re-evaluation and occurs over a 12-month rolling period. A visit may include any combination of physical/occupational therapy procedures.

**Chiropractic Services:**
Participating providers may render up to 24 visits to an eligible West Virginia Health Bridge member without prior authorization. Beginning with the 25th visit, prior authorization is required to continue treatment.

<table>
<thead>
<tr>
<th>Physician/PA/NP/NMW/FQHC/RHC services</th>
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</tr>
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</table>

<table>
<thead>
<tr>
<th>Private duty nursing</th>
<th>Provider-administered medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological Services</td>
<td>Psychological Services</td>
</tr>
<tr>
<td>Tobacco cessation</td>
<td>Tobacco cessation</td>
</tr>
<tr>
<td>Vision</td>
<td>Vision services (medical treatment only)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Abortion</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis drugs</td>
<td>Hepatitis drugs</td>
</tr>
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<td>Hemophilia factors</td>
<td>Hemophilia factors</td>
</tr>
<tr>
<td>Children (Age 19 to 20 years)</td>
<td>Adults (21 years and older)</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Outpatient pharmacy medications</td>
<td>Outpatient pharmacy medications</td>
</tr>
<tr>
<td>Personal care services</td>
<td></td>
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<tr>
<td>Nursing home services</td>
<td></td>
</tr>
<tr>
<td>Nonemergency transportation</td>
<td>Nonemergency transportation</td>
</tr>
<tr>
<td>School-based services</td>
<td></td>
</tr>
<tr>
<td>Transplants (except corneal transplants, which are covered by UniCare)</td>
<td>Transplants (except corneal transplants, which are covered by UniCare)</td>
</tr>
</tbody>
</table>

**Dental Services**

UniCare has contracted with Skygen Dental to provide fee-for-service dental services for children under the age of 21. The West Virginia Bureau for Medical Services (BMS) is not responsible for payment of covered services. Skygen Dental can be contacted as follows:

Phone: **1-877-724-6602**  
Hours: Monday to Friday, 8 a.m.-8 p.m.  
Website: [www.skygenusa.com](http://www.skygenusa.com)

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

**Dental Services: Dental Screening and Referral for Children Ages 0 to under 21**

For children ages 0 to under 21, services are covered and provided through Scion Dental. Children ages 0 to under 21 years of age are eligible for the following:

- Covered diagnostic
- Preventive
- Restorative
- Periodontics
- Prosthodontics
- Maxillofacial prosthetics
- Oral and maxillofacial surgery/services
- Orthodontics, for the entire duration of treatment

Prior authorization may apply.

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

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

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

Dental services following an accident or emergency are covered under UniCare and are provided by Skygen Dental. Emergency dental services are provided when a member has an accident and the dental work required is the initial repair of an injury to the jaw, sound natural teeth, mouth or face. The following services are covered by a dentist or oral surgeon:

- Treatment of fractures of the upper or lower jaw
- Biopsy
- Removal of tumors
- Removal of a tooth when it is an emergency

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

**Vision Services**

UniCare members under the age of 21 are eligible for vision services rendered by the following providers:

- Ophthalmologists
- Optometrists
- Opticians
- Surgeons

Covered services include the following:

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

Limits:

- Adult services are limited to medical treatment only.
- Prescription sunglasses and designer frames are not covered.

**Behavioral Health Services**

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

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

Behavioral health providers can be accessed directly by members and UniCare does not provide triage and referral services. Members do not have to contact UniCare for a referral.
**Court-Ordered Services**
UniCare will reimburse providers for court-ordered treatment services that are covered under the Medicaid State Plan and deemed medically necessary. The court order documentation must accompany the prior authorization (PA) request. The court order determination of medical necessity is subject to review, determination and the member appeal process.

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

**County and State-Linked Services**
To ensure continuity and coordination of care for our members, UniCare enters into agreements with locally based public health programs. Providers are responsible for notifying UniCare’s Case Management department when a referral is made to any of the West Virginia agencies listed below:
- Bureau for Behavioral Health: [www.dhhr.wv.gov/bhff](http://www.dhhr.wv.gov/bhff). Provides services for persons with mental illness, chemical dependency and developmental disabilities for reintegration into the community.
- Division of Local Health: [www.dhhr.wv.gov/localhealth](http://www.dhhr.wv.gov/localhealth). Serves as the state liaison to local health departments.
- Division of Rehabilitative Services (DRS): [www.wvdrs.org](http://www.wvdrs.org). Provides independence through in-home services, supported employment, independent living, nutrition, services for members with hearing loss, blindness or visual impairment and social security disability eligibility.
- Bureau for Children and Families (BCF): [https://dhhr.wv.gov/bcf/Pages/default.aspx](https://dhhr.wv.gov/bcf/Pages/default.aspx). BCF is a non-Medicaid program administered by the West Virginia Department of Health and Human Resources (DHHR) that provides a number of different programs for children and their families, including protective services, financial assistance and food stamps. Phone: **1-800-642-8589**

Unicare Case Management phone: **1-304-347-2475**
Unicare Case Management email: wvcmrreferrals@anthem.com

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

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

**Directly Observed Therapy**

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

**Reportable Diseases**

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

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

Sexually Transmitted Disease Program: Per WV Statute Chapter 16-4-6 and Legislative Rules Title 64, Series 7, practitioners and providers must report cases involving a sexually transmitted disease to the Division of Surveillance and Disease Control.

Tuberculosis Program: Per WV Statute Chapter 26-5A-4 and WV Regulations 16-25-3, practitioners and providers must report individuals with diseases caused by M. tuberculosis to the WV Bureau for Public, DSDC, and TB Program.

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

**Telehealth**

Telehealth is the use of electronic information and telecommunications technologies to provide health care professionals the ability to connect patients with clinical experts in large hospitals or academic medical centers and can assure that patient in remote areas enjoy the same access to potentially life-saving technologies and expertise that are available to patients in more populated parts of the country. The telecommunication system is defined as an interactive audio and video system that permits real time communication between the member at the originating site and the practitioner at the distant site. The telecommunication technology must allow the treating practitioner at the distant site to perform a medical examination of the member that substitutes for an in-person encounter.

**Note:** Utilizing telehealth does not require prior authorization.
Telehealth is used in the delivery of health care services through the use of a secure interactive audio video platform for the purpose of diagnosis, consultation, and/or treatment of a covered injured worker in a location separate from the servicing provider. Telehealth services do not include the use of audio-only telephone, facsimile machine, or electronic mail.

**Telehealth** can connect a provider's office to a **specialty center** by:
- **Live video consult:** The PCP and specialist meet at the same time using HIPAA compliant video conferencing technology.

Telehealth offers multiple benefits to providers and members:
- The member can continue to be cared for by their local provider.
- The member does not need to travel long distances to receive specialist care.
- The PCP receives all records and test results from the encounter.
- The PCP consults with the specialist participating in the telehealth encounter to design any necessary course of treatment.

Telehealth can also be used for nonclinical consults such as community services, continuing medical education and other provider training sessions.

To find out more about telehealth, or for contracting questions, please call Customer Care Center at 1-800-782-0095.

**Equipment Standards and Requirements**
To utilize telehealth services and render them effectively, providers must ensure that they follow all equipment standards and requirements as listed below:
- **Minimum equipment standards** are transmission speeds of 256kbps or higher over Integrated Services Digital Network (ISDN) or proprietary network connections including Virtual Private Networks (VPNs), fractional T1, or T1 comparable cable bandwidths. Software that has been developed for the specific use of Telehealth may be used if the software is Health Insurance Portability and Accounting Act (HIPAA) compliant and abides by a federal code pertaining to Telehealth.
- The audio, video, and/or computer telemedicine system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telemedicine. The telecommunication equipment must be of a quality to complete adequately all necessary components to document the level of service for the CPT® codes that are available to be billed. If a peripheral diagnostic scope is required to assess the patient, it must provide adequate resolution or audio quality for decision-making. The provider at the distant site is responsible to maintain standards of care within the scope of practice.
- All Medicaid conditions and regulations apply to Telehealth services unless otherwise specified in this manual.
- All providers are required to develop and maintain written documentation of the services provided in the form of progress notes. The notes must meet the same guidelines as those required of an in-person visit or consultation, with the exception that the mode of communication (for example, Telehealth) must be noted.
- The operator of the Telehealth equipment must be an enrolled provider or an employee of the enrolled provider for compliance with confidentiality and quality assurance.
- The practitioner who delivers the service to a member shall ensure that any written information is provided to the member in a form and manner which the member can understand using reasonable accommodations when necessary.
• Member’s consent to receive treatment via Telehealth shall be obtained and may be included in the member’s initial general consent for treatment.
• Members may utilize Telehealth through their personal computer by utilizing a VPN established and maintained by the provider and meeting the equipment standards stated in this policy.
• Telehealth services are available via web-based applications and/or smartphone applications (apps) as long as they meet the current HIPAA and 42 CFR Part 2 regulations of compliance and utilize a VPN.
• If the member (or legal guardian) indicates at any point that he or she wishes to stop using the technology, the service should cease immediately, and an alternative method of service provision should be arranged.
• The provider who has the ultimate responsibility for the care of the patient must first obtain verbal and written consent from the recipient, including the following information:
  o The right to withdraw at any time
  o A description of the risks, benefits, and consequences of telemedicine
  o Application of all existing confidentiality protections Right of the patient to documentation regarding all transmitted medical information
  o Prohibition of dissemination of any patient images or information to other entities without further written consent.
• BMS Provider Manual standards apply to all services available through Telehealth unless otherwise described. Medicaid will reimburse according to the fee schedule for services provided.
• Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), third party applications that are not HIPAA compliant (for example, Skype, FaceTime, etc.) or facsimile transmission (fax) between a provider and a member.

Authorized distant site providers include:
- Physician Assistant (PA).
- Advanced Practice Registered Nurse (APRN).
- Certified Nurse Midwife (CNM).
- Clinical Nurse Specialist (CNS).
- Community Mental Health Center (CMHC).
- Licensed Behavioral Health Center (LBHC).
- Licensed Psychologist (LP) and Supervised Psychologist (SP).
- Licensed Independent Clinical Social Worker (LICSW).
- Licensed Professional Counselor (LPC), and FQHC and RHC may only serve as a distant site for Telehealth services provided by a psychiatrist or psychologist and are reimbursed at the encounter rate.

**WIC Referrals**
The WIC program provides healthy food to pregnant women and mothers of young children. Providers have the following responsibilities for WIC program referrals:
- Complete the *WIC Program Referral Form*, documenting the following information:
  o Anthropometric data (height, current weight, pregravid weight)
  o Any current medical conditions
  o Biochemical data (hemoglobin, hematocrit)
  o Expected date of delivery
- Provide the member with the completed referral form. The member then presents the referral form to the local WIC agency.

The *WIC Program Referral Form* may be found on the state’s website at [https://ons.wvdhhr.org](https://ons.wvdhhr.org)
West Virginia WIC phone: 1-304-558-0030
Overview
Given the increasing complexities of health care administration, widespread potential for fraud and abuse, and constant fluctuations in program membership, providers need to be vigilant about member eligibility. This may mean taking extra steps to verify that any patient is, in fact, a currently-enrolled UniCare member.

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

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

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

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

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

- Member name
- Member ID number
- Coverage code
- Effective date
- PCP name and address
- Contact numbers: UniCare Customer Care Center, 24/7 NurseLine, vision, dental, eligibility, preapproval/hospital admissions
- Address for medical claim submission
If a card is lost, members may receive replacement cards upon request through our Customer Care Center or the member website. If the member transfers to a new PCP, UniCare issues a new ID card or the member can print a new card by logging in to the member website.

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

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

**West Virginia Mountain Health Trust**

*Front of card*

![Sample Front of West Virginia Mountain Health Trust ID Card]

*Back of card*

![Sample Back of West Virginia Mountain Health Trust ID Card]
West Virginia Health Bridge

Front of card

![Front of West Virginia Health Bridge card](image)

Back of card

![Back of West Virginia Health Bridge card](image)
CHAPTER 6: UTILIZATION MANAGEMENT

Utilization Management phone: 1-866-655-7423
Utilization Management fax: 1-855-402-6983 (preservice reviews) or 1-855-402-6985 (current inpatient reviews)
Behavioral Health Inpatient fax: 1-855-325-5556
Behavioral Health Outpatient fax: 1-855-325-5557
Psychological Testing fax: 1-855-325-5557
Availity Portal: https://www.availity.com
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

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

Overview

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

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

- Benefit coverage
- Established criteria
- Community standards of care

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

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

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

- Prior authorizations
- Continued stay reviews
- Post service reviews, when requested within 3 business days of the service being rendered

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

- American College of Cardiology
- American College of Obstetricians and Gynecologists
American Academy of Pediatrics
American Academy of Orthopedic Surgeons
American Psychiatric Association
American Society of Addiction Medicine
Cumulative professional expertise and experience

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

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

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

Because we do not want the review process to delay care for our members, we accept prior authorization requests within three business days of the service being rendered. Clinical information for requests for services beyond three business days should be submitted with claims for post service clinical claims review. Documentation should support that the service provided was an emergency or show why the provider could not obtain prior authorization timely. The UM department does not backdate authorization requests beyond three business days.

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

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

Generally speaking, the provider is responsible for contacting the UM department to request preservice review for both professional and institutional services. However, the hospital or ancillary provider should contact UniCare to verify preservice review status for all nonurgent care before rendering services. The hospital can confirm that an authorization is on file by calling 1-800-782-0095 or using the Interactive Care Reviewer (ICR), our online self-service authorization tool via Availity. If coverage of an admission has not been approved, the facility should call UniCare’s UM department at 1-866-655-7423 to start the UM process.
UniCare is available by fax or ICR 24 hours a day, 7 days a week to accept prior authorization requests. When a request for medical services is received from the physician via telephone or fax, the intake representative will verify eligibility and benefits. This information will be forwarded to the prior authorization nurse or clinician.

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

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

If you disagree with a UM decision and want to discuss the decision with the physician or peer reviewer, call the peer-to-peer number at 1-866-902-4628, option 3 and leave the pertinent information on the voice mail. The medical director or peer reviewer will return your call at the time you request. All peer-to-peer discussions must be requested within two business days of the denial notification.

**Services Requiring Prior Authorization**

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

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

The Precertification Lookup Tool Online can assist with determining a code’s precertification requirements, located at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.
**Services Not Requiring Prior Authorization**

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

- Behavioral health screening and assessment
- Community Psychiatric Supportive Treatment (First three days of treatment)
- Emergency services (notify UniCare within 24 hours or the next business day of inpatient admission)
- Family planning/well-woman checkups:
  - Birth control
  - Breast and pelvic exams
  - U.S. Food and Drug Administration (FDA)-approved devices and supplies for family planning
  - Genetic counseling
  - Screening for HIV or sexually transmitted infections (STIs)
  - Lab work
- Nebulizers
- Obstetrical care:
  - In-network physician visits and routine testing: no authorization required.
  - Newborn delivery notification: Notification is required using the *Newborn Enrollment Notification Report*, available on our website at [www.unicare.com](http://www.unicare.com). For directions on how to access the provider website, please see *Chapter 1: How to Access Information, Forms and Tools on Our Website*. Complete the entire form and fax it to: 1-855-402-6985.
- Physical and occupational therapy (subject to limits)
- Physician referrals (for in-network specialists, consultation or a nonsurgical course of treatment)
- Services where UniCare is the secondary payer
- Standard X-rays and ultrasounds (limited to one prenatal ultrasound per normal pregnancy)

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

The PRSI and *Newborn Enrollment Notification Report* form are in the *Forms and Tools* section of the *Provider Resources* page on our website at [www.unicare.com](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*. 
Starting the Process
When authorization of a health care service is required, contact us with questions and requests, including requests for:

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

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

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

The UM department returns calls:

- Same day when the call is received during normal business hours
- Next business day when the call is received after normal business hours

Providers may fax the UM department and include requests for:

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

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

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

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

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

Ask your Availity administrator to grant you the required ICR role assignment:
- To create and submit prior authorization requests you need the Authorization and Referral Request role assignment
- To check the status of the case or results of the authorization request you need the Authorization and Referral Inquiry role assignment

For an optimal experience with the ICR, use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox and Safari. The ICR is not currently available for:
- Transplant services.
- Services administered by vendors, such as AIM Specialty Health® and OrthoNet LLC. For these requests, follow the same prior authorization process you use today.

**Requesting Authorization**

To request a preservice review or report a medical admission, call, fax or submit a request electronically through the ICR from the Availity Portal for UniCare. Have the following information ready:
- Member name and identification (ID) number
- Diagnosis with the ICD code
- Procedure with the CPT code
- Date of injury or hospital admission
- Third-party liability information (if applicable)
- Servicing provider and facility name, TIN and NPI
- PCP
- Provider or attending physician name, TIN and NPI
- Clinical justification for the request
- Level of care
- Lab tests, radiology and pathology results
- Medications
- Treatment plan, including time frames
- Prognosis
- Psychosocial status and history
- Exceptional or special needs issues
- Ability to perform activities of daily living
- Discharge plans
- ASAM dimensions
- Court-ordered documents (when applicable)

All providers, including physicians, hospitals and ancillary providers are required to provide information to the UM department. Physicians are encouraged to review their utilization and referral patterns. Additional information to have ready for the clinical reviewer includes:
- Office and hospital records
- History of the presenting problem
- Clinical exam
- Treatment plans and progress notes
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and Providers
• Photographs
• Operative and pathological reports
• Rehabilitative evaluations
• Printed copy of criteria related to the request
• Information regarding benefits for services or procedures
• Information regarding the local delivery system
• Patient characteristics and information
• Information from responsible family members

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

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

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

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

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.
Fax Authorization Requests
A fax form is available at www.UniCare.com. Fax your request to:

- Preservice review fax: 1-855-402-6983
- Current inpatient review fax: 1-855-402-6985
- Behavioral Health inpatient fax: 1-855-325-5556
- Behavioral Health outpatient fax: 1-855-325-5557

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

Electronic Review Time Frame
For routine, nonurgent requests submitted via ICR, the UM department will review the request for complete information within two business days of the request. If we require additional information, we will send you a request for information (RFI) letter. We will then make a decision within seven calendar days of the request date based on the information we have at that time.

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

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

Behavioral Health numbers:
- 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

Coverage of emergent admissions is authorized based on review by a licensed concurrent stay review (CSR) nurse or clinician. When the clinical information received meets criteria, an authorization will be issued to the hospital. If the notification documentation provided is incomplete or inadequate, the CSR nurse or clinician will not approve the request and will refer the request to the UniCare medical director. If the medical director denies coverage of the request, the appropriate denial letter, including the member’s appeal rights, will be sent to the hospital, the member’s PCP and the member.
Members who call their PCP’s office reporting a medical emergency (whether during or after office hours) are directed to dial 911 or go directly to the nearest hospital emergency department. All nonemergent conditions should be triaged by the PCP or treating physician, with appropriate care instructions given to the member.

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

The emergency department should send a copy of the emergency room record to the PCP’s office within 24 hours. The PCP should:
- Review and file the chart in the member’s permanent medical record
- Contact the member
- Schedule a follow-up office visit or a specialist referral, if appropriate

As with all nonelective admissions, notification must be made the next business day. The medical necessity of the admission will be reviewed upon receipt of the notification. A determination of the medical necessity will be rendered within 72 hours of the notification. Failure to comply with notification rules will result in an administrative denial. UniCare intake staff will verify eligibility and determine benefit coverage. UniCare is available via fax at 1-855-402-6985 or ICR 24 hours a day, 7 days a week to accept emergent admission notification.

Behavioral Health numbers:
- 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

**Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)**
This HEDIS® measure assesses emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:
1. ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

**Referrals to Specialists**
The Customer Service or Case Management departments are available to assist providers in identifying a network specialist and/or arranging for specialty care. Keep in mind the following when referring members. Authorization is:
- Not required if referring a member to an in-network specialist for consultation or a nonsurgical course of treatment.
- Required when referring a member to an out-of-network specialist.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
Provider responsibilities include documenting referrals in the member’s chart and requesting that the specialist provide updates about diagnosis and treatment. Treatment provided by the specialist must be appropriate for the member’s condition.

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

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

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

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

**Continued Stay Review: Clinical Information for Continued Stay Review**
When a member’s hospital stay is expected to exceed the number of days authorized during preservice review, or when the inpatient stay did not require preservice review (that is, emergency admission), the hospital must contact us for continued stay review. We require clinical reviews on all members admitted as inpatients to:
- Acute care hospitals
- Intermediate facilities.
- Inpatient rehabilitation facilities.
- Inpatient Behavioral Health and Substance Use Disorder facilities.
- Psychiatric Residential Treatment facilities.
- Substance Use Disorder Residential Adult Services.

**Note:** Failure to notify UM within the designated time frame can result in an administrative denial of services.
We perform these reviews to assess medical necessity and determine whether the facility and level of care are appropriate. UniCare identifies members admitted as inpatients by:

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

The UM department will complete continued-stay inpatient reviews within 72 hours of receipt of the request, consistent with the member’s medical condition. UM staff will request clinical information from the hospital on the same day they are notified of the member’s admission and/or continued stay. If the information meets medical necessity review criteria, we will approve the request within 72 hours of receipt of the information. Requests that do not meet criteria for medical necessity are sent to the physician advisor or medical director for further review. We will send written notification to the member, requesting provider and servicing provider and facility, as applicable, of any denial or modification of the request.

**Denial of Service**

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

- Procedures.
- Hospitalization.
- Equipment.

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

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

- The decision.
- The process for appeal.
- How to reach the reviewing physician or peer reviewer for peer-to-peer discussion of the case.
- The reason and the criteria used to make the decision.

Providers may contact the physician clinical reviewer to discuss any UM decision by calling the peer to peer line at 1-866-902-4628, option 3 within two business days of the denial notification.

**Self-Referral**

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

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

**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.

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

- Phone: 1-866-655-7423
- Behavioral Health Inpatient Fax: 1-855-325-5556
- Behavioral Health Outpatient Fax: 1-855-325-5557
- Hours: Monday to Friday, 8 a.m.-5 p.m.
- Website: www.unicare.com

Behavioral Health Timeliness of Decisions on Requests for Authorization

<table>
<thead>
<tr>
<th>Behavioral Health</th>
<th>1. Urgent, pre-service requests: within 72 hours of request</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Urgent concurrent requests: within 24 hours of request</td>
</tr>
<tr>
<td></td>
<td>3. Routine, nonurgent requests: within 7 calendar days of receiving request</td>
</tr>
<tr>
<td></td>
<td>4. Post-service review requests: within 30 days of request</td>
</tr>
</tbody>
</table>

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.

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

Additional Services: Dental Care
UniCare covers emergency dental services only for adults 21 years of age and older. These services may be given by a dentist or oral surgeon.

We cover:
- Treatment of fractures of the upper or lower jaw
- Biopsy
- Removal of tumors
- Removal of a tooth when it is an emergency

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

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

Overview

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

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

Healthy Rewards

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

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

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

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Fee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st prenatal visit (within 42 days of enrollment)</td>
<td>$25</td>
<td>Once per pregnancy</td>
</tr>
<tr>
<td>Six prenatal care visits</td>
<td>$25</td>
<td>Once per pregnancy</td>
</tr>
<tr>
<td>Postpartum Visit between 7 - 84 days after delivery</td>
<td>$25</td>
<td>Once per pregnancy</td>
</tr>
<tr>
<td>Annual Dental Visit Ages 0-20</td>
<td>$25</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Member age 6-12 prescribed ADHD medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete follow up visit with prescriber within 30 days of initial RX</td>
<td>$25</td>
<td>Once</td>
</tr>
<tr>
<td>Complete Health Needs Screener</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult ages 18+</td>
<td>$10</td>
<td>Once</td>
</tr>
</tbody>
</table>

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

If your patients have questions regarding the program, please have the member call **1-888-990-8681** for more information.

**Preventive Care: Health Screenings and Immunizations**

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

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

**Provider Responsibilities**

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

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

**Preventive Care: Initial Health Assessments**

The initial health assessment (IHA) gives providers the baseline necessary to assess and manage a member’s physical condition. Once the IHA has been completed, providers can give our members the kind of educational support that allows members to become more actively engaged in their own treatment and preventive health care.
The IHA of new members should be performed by the PCP within 90 days of enrollment. The IHA consists of the following categories of patient information:

- Patient history
- Physical examination
- Developmental assessment

Please note: An IHA is not necessary under the following conditions:

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

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

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

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

UniCare HealthCheck Responsibilities
Information on our preventive care programs is provided in UniCare’s Member Handbook, which is sent to members at the time of enrollment. Member newsletters and the member website include special features about the HealthCheck program, and ongoing reminders on the importance of an IHA, well-child visits, immunizations and regular checkups.
In addition, UniCare provides services, which may include live calls, Interactive Voice Response (IVR) outreach, or mailed materials to reach out to members as outlined below:

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

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

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

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

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

**Preventive Care: Well Woman**

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

PCP responsibilities for the care of female members include:

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

Providers may access the Preventive Health Care Guidelines in the *Quality Improvement Program* section on our website at [www.unicare.com](http://www.unicare.com). For directions on how to access our website, please see *Chapter 1: How to Access Information, Forms and Tools on Our Website*.

**Health Management: Taking Care of Baby and Me®**

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

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. Case managers collaborate with community agencies to ensure mothers have access to necessary services, including transportation, WIC, home-visitor programs, breastfeeding support and counseling.
When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That’s why we encourage all of our moms-to-be to take part in our program, which offers:

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

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

**Provider Assessment of Pregnancy Risk**
The PCP or prenatal care physician should assess all pregnant members for high-risk indicators during the initial prenatal care visit. For all pregnant members, the provider needs to:

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

You should also complete the Availity platform’s Maternity Module:

- Perform an Eligibility and Benefits request on a UniCare member and choose one of the following benefit service types: maternity, obstetrical, gynecological, obstetrical/gynecological.
- Before you see the benefit results screen, you will be asked if the member is pregnant and given a **Yes** or **No** option. If you indicate **Yes**, you will be asked what the estimated due date is. IF you do not yet have an estimated date, you can leave this blank.
After you submit your answer, you will be taken to the Benefits page like normal. In the background, a Maternity Module will have been generated for this patient in the Maternity application in the Payer Spaces for UniCare.

For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the You and Your Baby in the NICU program and a NICU Post-Traumatic Stress Disorder (NICU PTSD) program:

- Parents receive education and support to be involved in the care of their babies, visit the NICU, interact with hospital care providers and prepare for discharge.
- Parents are also provided with an educational resource outlining successful strategies they may deploy to collaborate with the care team.
- The NICU PTSD program seeks to improve outcomes for families of babies who are in the NICU by screening and facilitating referral to treatment for PTSD in parents. This program will support mothers and families at risk for PTSD due to the stressful experience of having a baby in the NICU.

**Breastfeeding Support Tools and Services**

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

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

**Health Education: 24/7 NurseLine**

We recognize that questions about health care prevention and management do not always come up during office hours. The 24/7 NurseLine, a phone line staffed by registered nurses, offers a provider support system and is a component of after-hours care. The 24/7 NurseLine allows members to closely monitor and manage their own health by providing the ability to ask questions whenever they come up. This phone line is available 24 hours a day, 7 days a week at **1-888-850-1108**.
Members may call the 24/7 NurseLine for:
- Self-care information, including assistance with symptoms, medications and side-effects, and reliable self-care home treatments
- Access to specialized nurses trained to discuss health issues specific to our teenage members
- Information on more than 300 health care topics through the audio tape library

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

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

**Health Education: Emergency Room Action Campaign**

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

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

The ER Action Campaign is a multi-pronged communication program that includes the following:
- IVR calls made to members identified through a clinical analysis of members’ medical claims. The IVR provides a predefined, finite list of barriers for the member to select to identify the reason for going to the ER rather than to a PCP.
- After completing the call, members either are warm transferred to the outbound call center (OBC) or are given information about how to contact the 24/7 NurseLine. The OBC also helps members who need information about their PCP or transportation assistance. The 24/7 NurseLine helps members determine if they have a medical emergency requiring a visit to the ER and provides assistance with other concerns, such as filling medications.
- A member’s responses from the IVR call are used to generate a customized mailing to the member. The mailing addresses the barriers identified during the IVR call and provides resources the member can use instead of going to the ER, such as visiting their PCP.

We rely on the support of the providers, who remind members that the PCP’s office and the 24/7 NurseLine should be their first stops for nonemergency conditions. Working together, we can replace the automatic urge to go to the emergency room with the more appropriate action of picking up the phone or returning to the PCP’s office.
Health Education: Weight Watchers Membership

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

- Toll-free phone: 1-888-611-9958
- Local phone: 1-304-347-1961

Health Education: Tobacco Cessation Programs

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

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

- Smokefree.gov
- Pubs.cancer.gov: The National Cancer Institute

The Smoking Cessation program helps members in any stage of cessation readiness and includes the following:

- UniCare offers smoking cessation classes to members at no cost; call the Customer Care Center for more information
- Nicotine replacement therapy (NRT) — when prescribed by a provider

Smoking cessation Clinical Practice Guidelines are posted on our website at www.unicare.com. For directions on how to access our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Provider Assessment of Tobacco Use

The following are provider guidelines to help members quit smoking:

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

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

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

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

Counseling is required as a part of any covered tobacco cessation course of treatment.
CHAPTER 8: 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, gender, gender identity, physical disability or other characteristics.
- Oriented to recovery, providing services that are flexible and evolve over time.

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

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

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.

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.

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.
CHAPTER 9: CLAIMS AND BILLING

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

Overview

Having a fast and accurate system for processing claims allows providers to manage their practices and our members’ care more efficiently. With that in mind, UniCare has made claims processing as streamlined as possible. Share the following guidelines with your staff, billing service and electronic data processing agents:

- Submit clean claims, making sure that the right information is on the right form.
- Submit claims as soon as possible after providing service.
- Submit claims within the contract filing time limit.

Additional information covered in this chapter includes the following:

- Covered services
- Clinical submission categories
- Benefit codes
- Submitting present on admission indicators
- Submitting pregnancy notification reports
- National drug codes
- Common reasons for rejected and returned claims

Claims Editing

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

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

Clear Claim Connection

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

Submitting Clean Claims

Claims submitted correctly the first time are called clean, meaning that all required fields have been filled in and that the correct form was used for the specific type of service provided. The provider is responsible for all claims submitted using the provider number, regardless of who completed the claim 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 HIPAA-compliant code set. In each case, an error report will be sent to you and the claim will not be sent through for payment. You and your staff are responsible for working with your EDI vendor to ensure that “errored out” claims are corrected and resubmitted.

Generally, the types of forms you will need for reimbursement are:

- CMS-1500 for professional services: [www.cms.gov/Medicare/CMS-Forms](http://www.cms.gov/Medicare/CMS-Forms)

These forms are available in both electronic and hard copy/paper formats.

**Please note:** Using the wrong form, or not filling out the form correctly or completely, causes the claim to be returned, resulting in processing and payment delays.

**ICD-10**

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

**What is ICD-10?**

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

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:

- ICD-10-CM (Clinical Modification) used for diagnosis coding, and
- ICD-10-PCS (Procedure Coding System) used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

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

**Claims 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.

**Claim Forms and Filing Limits**

Refer to the provider contract to confirm the time limits to file.

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

**Other Filing Limits**

<table>
<thead>
<tr>
<th>Action</th>
<th>Type of service to be billed</th>
<th>Time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Third-Party Liability (TPL) or Coordination of Benefits (COB)</strong></td>
<td>If the claim has TPL, COB or requires submission to a third party before submitting to UniCare, the filing limit starts from the date on the notice from the third party.</td>
<td>File within 180 days of notice from the third-party vendor.</td>
</tr>
<tr>
<td><strong>Checking Claim Status</strong></td>
<td>Claim status may be checked any time by calling the Customer Care Center Interactive Voice Response (IVR) system or by visiting the Availity Portal at <a href="https://www.availity.com">https://www.availity.com</a>.</td>
<td>30 business days after UniCare’s receipt of a claim, submit a Follow-Up Request Form. Or, call the Customer Care Center IVR.</td>
</tr>
<tr>
<td><strong>Action</strong></td>
<td><strong>Type of service to be billed</strong></td>
<td><strong>Time frame</strong></td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td><strong>Claim Follow-Up Request</strong></td>
<td>Submit a corrected claim after UniCare’s denial or correction to a claim, or to follow up on a claim using the <em>Claim Follow-Up Form</em>. To access this form, go the provider website at <a href="http://www.unicare.com">www.unicare.com</a>. For directions on how to access the provider website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.</td>
<td>180 calendar days from the date of our remittance advice.</td>
</tr>
<tr>
<td><strong>Mailback Form</strong></td>
<td>UniCare sends a request for additional information to you when we cannot process your claim due to incomplete, missing or incorrect information in the original claim submission.</td>
<td>Return the requested information within 180 calendar days. In your response, include a copy of the Mailback Form you received, all supporting documentation deemed pertinent or requested by us (such as records or reports), and a copy of the original/corrected claim.</td>
</tr>
<tr>
<td><strong>Claim Filing with Wrong Health Plan/Insurance Carrier</strong></td>
<td>If the claim was mistakenly filed with the wrong health plan or insurance carrier, you may submit to us with the proper documentation for payment.</td>
<td>Provide documentation verifying the initial timely filing. Submit to us within 180 days of the date of the other carrier’s denial letter or RA form. We will process your claim without denial for failure to file within time limits.</td>
</tr>
<tr>
<td><strong>Provider Claim Payment Dispute</strong></td>
<td>Submit a Provider Claim Payment Dispute in 3 different ways: 1. Customer Service 2. Provider Portal – Availity 3. Written: UniCare Health Plan of West Virginia, Inc. Attn: Provider Claim Payment Dispute Team P.O. Box 91 Charleston, WV 25321-0091</td>
<td>First-level dispute – Reconsideration – 180 calendar days from the date on the remittance advice. Second-level dispute – Claim Payment Appeal – 60 calendar days from the date on the Reconsideration Determination Letter</td>
</tr>
<tr>
<td><strong>Acknowledgement Letter</strong></td>
<td>This process provides UniCare with response time to investigate and make a determination.</td>
<td>UniCare sends an acknowledgement within 15 calendar days of receipt of the dispute.</td>
</tr>
</tbody>
</table>
UniCare’s Response to Provider Dispute Resolution Request

<table>
<thead>
<tr>
<th>Action</th>
<th>Type of service to be billed</th>
<th>Time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A resolution letter is sent to the provider with the determination made on the dispute submission.</td>
<td>First-level dispute – Reconsideration We make a determination within 45 business days of receipt of the dispute.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Second-level dispute – Claim Payment Appeal We make a determination within 30 calendar days of receipt of the dispute.</td>
</tr>
</tbody>
</table>

Methods for Submission

The methods for submitting a claim are as follows:

- Electronically through Electronic Data Interchange (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.

Electronic Claims

UniCare encourages the submission of claims electronically through the Electronic Data Interchange (EDI).

UniCare has transitioned into a strategic relationship with Availity to serve as our EDI gateway for all electronic data and transactions. UniCare encourages electronic claims submission, either by using a Clearinghouse, Billing company or sending directly.

Providers can also register with Availity at www.availity.com to become a direct submitter. To initiate the electronic claims submission process or obtain additional information, contact Availity Client Services at 1-800-Availity (1-800-282-4548). Availity Client Services is available Monday through Friday from 8 a.m. to 7 p.m. ET.

The advantages of electronic claims submission are as follows:

- Facilitates timely claims adjudication
- Acknowledges receipt and rejection notification of claims electronically
- Improves claims tracking
- Improves claims status reporting
- Reduces adjudication turnaround
- Eliminates paper
- Improves cost-effectiveness
- Allows for automatic adjudication of claims
The guide for EDI claims submission is located at www.unicare.com/edi. The EDI Claim Submission Guide includes additional information related to the EDI claim process.

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

**National Provider Identifier**
The NPI is a 10-digit, all numeric identifier. NPIs are issued only to providers of health services and supplies. As a provision of HIPAA, the NPI is intended to improve efficiency and reduce fraud and abuse. NPIs are divided into the following types:
- Type 1: Individual providers, including, but not limited to, physicians, dentists, chiropractors, psychiatrists and psychologists
- Type 2: Hospitals and medical groups, including, but not limited to, hospitals, group practices, federally qualified health centers (FQHCs), rural health clinics (RHCs), comprehensive behavioral health centers (COMPs), community mental health centers (CMHCs) and licensed behavioral health centers (LBHCs)

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

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

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

The following websites offer additional NPI information:
- CMS: www.cms.gov
- NPPES: https://npiregistry.cms.hhs.gov
- Workgroup for EDI: http://www.wedi.org
- National Uniform Claims Committee: www.nucc.org

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

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

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

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

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

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.

Member Balance Billing
Providers contracted with UniCare may not balance bill our members, meaning that members cannot be charged for covered services above the amount UniCare pays to the provider. A West Virginia BMS program provider may bill a member only when all of the following conditions have been met:
- The service is not covered or the member has exceeded the program limitations.
- The member understands, before services are rendered, that the service is not covered and that the member is responsible for the charges associated with the service.
- The provider documents that the member voluntarily chose to receive the service and that the member was informed in advance that he or she was receiving a noncovered service.

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

Providers may balance bill a member when prior authorization of a covered service is denied. However, the provider must establish and demonstrate compliance with all of the following:
- Establish that prior authorization was requested and denied before rendering service.
- Notify the member that the service requires prior authorization and that UniCare has denied authorization. If out-of-network, the provider must explain to the member that covered services may be available without cost when provided by an in-network provider. In such cases, authorization of service is required.
• Inform the member of his or her right to file an appeal if the member disagrees with the decision to deny authorization.
• Inform the member of his or her responsibility for payment of nonauthorized services.

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

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

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

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

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

Claims 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

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.
If payment is not warranted, UniCare sends an RA to the provider with the specific claims processing information.

UniCare will adjudicate a clean electronic claim within 30 calendar days of the date the claim is received. Clean paper claims are processed within 30 calendar days. UniCare will pay interest on clean claims not adjudicated within these timeframes. This policy is in alignment with BMS reimbursement policies. Interest will be paid to the in-network provider at 18% per annum, calculated daily for the full period in which the clean claim remains unpaid beyond the 30-day clean claim payment deadline.

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

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

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

**Electronic Remittance Advice**
UniCare offers secure electronic delivery of RAs, which explain claims in their final status, using EDI.

All changes or new registrations for the 835 Electronic Remittance Advice now direct to Availity. Existing 835 deliveries are also transitioning to the Availity EDI Gateway:

- Availity Client Services at 1-800-Availity (1-800-282-4548).
- Availity Client Services is available Monday through Friday from 8 a.m. to 7 p.m. ET.

Choose to suppress (or enable) paper remittance vouchers through our Provider Paper Suppression Form.

**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 will need to use the Council for Affordable Quality Health Care (CAQH) Enrollment tool, a secured electronic EFT 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.

To register or manage account changes for electronic funds transfers, use the secure EnrollHub™, a CAQH enrollment tool.
Claims Overpayment Recovery Procedure
UniCare seeks recovery of all excess claims payments from the person or entity to whom the benefit check is made payable. When an overpayment is discovered, UniCare initiates the overpayment recovery process by sending written notification.

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

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

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

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

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

The provision entitled Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments, codified at 42 U.S.C.A. § 1320a-7k, clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act. This provision of the HealthCare Reform Act applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.
UniCare seeks recovery of all excess claims payments from the person or entity to whom the benefit check is made payable. When an overpayment is discovered, UniCare initiates the overpayment recovery process by sending written notification.

If you are notified by UniCare of an overpayment, or discover that you have been overpaid, mail the check, along with a copy of the notification or other supporting documentation within 30 days to the appropriate address:

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

For overnight delivery:

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

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

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

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.

Hospital Readmissions Policy
UniCare does not reimburse for readmission for a related condition within 30 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 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.

**Claim Resubmissions**

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

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

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

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

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

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

**Provider Claim Payment Disputes**

If you are not satisfied with the outcome of a claim payment decision, you may begin the claim payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized, but you disagree with the outcome.

The Provider Claim Payment Dispute process consists of the following linear steps:

1. **Reconsideration**
2. **Claim Payment Appeal**
Please be aware there are three common, claim related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, we’ve defined them briefly here:

**Claim Inquiry:** A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of a claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Customer Care Center (CCC) helps you with claim inquiries. Just call **1-800-782-0085** and select the **Claims** prompt within our voice portal. We connect you with dedicated resource team, called the Customer Care Center, to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The CCC is available to assist you in determining the appropriate process to follow for resolving your claim issue.

You can also visit the Availity Portal at [https://www.availity.com](https://www.availity.com).

**Claim Correspondence**

Correspondence is when UniCare requires more information to finalize a claim. Typically, UniCare makes the request for this information through the *Explanation of Payment (EOP)*. The claim or part of the claim may, in fact, be denied, but is only because more information is required to process the claim. Once the information is received, UniCare will use it to finalize the claim.

**Medical Necessity Appeals**

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

A Provider Claim Payment Dispute may be submitted for multiple reason(s), including:

- Contract payment issues.
- Disagreements over reduced or zero-paid claims.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely Filing issues*

*We will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.
Claim Payment Reconsiderations
The first step in the Claim Payment Dispute process is called Reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a Reconsideration without a finalized claim on file.

We accept Reconsideration requests in writing, verbally and through our secure provider website within 180 calendar days of the date on the Explanation of Payment. Reconsiderations filed more than 180 calendar days from the Explanation of Payment are considered untimely and denied unless good cause can be established.

When submitting Reconsiderations, include as much information as you can to help us understand why you think the claim was not paid as you would expect.

Upon receipt of your Reconsideration request, an acknowledgement letter will be sent to you within 15 business days of our receipt. We will conduct an internal review that includes a thorough investigation of the claim payment by a trained analyst utilizing all applicable statutory, regulatory, contractual and provider subcontract provisions, UniCare policies and procedures, and all pertinent facts submitted from all parties.

The results will then be communicated to you in a determination letter within 45 business days of the receipt of the reconsideration. If the outcome of the Reconsideration requires an adjustment to a claim payment, the adjustment will take place within 15 business days of the Reconsideration decision.

Claim Payment Appeal
If you are unsatisfied with the outcome of the Claim Payment Reconsideration, you may submit a Claim Payment Appeal within 60 calendar days of the Claim Payment Reconsideration outcome. You may submit your Claim Payment Appeal via Provider Online Portal or in writing. Verbal submissions are not accepted.

Upon receipt of your Claim Payment Appeal, an acknowledgement letter will be sent to you within 15 business days of our receipt. The results will then be communicated to you in a determination letter within 30 days of the receipt of the Claim Payment Appeal. If the outcome of the Claim Payment Appeal requires an adjustment to a claim payment, the adjustment will take place within 15 business days of the Claim Payment Appeal decision.

How to submit a Claim Payment Dispute
- **Online (for Reconsiderations and Claim Payment Appeals):** Use the secure Provider Availity Payment Appeal Tool at [https://www.availity.com](https://www.availity.com).
  **Note:** Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission.
- **Verbally (for Reconsiderations only):** call the Customer Care Center: 1-800-782-0085
- **Written (for Reconsiderations and Claim Payment Appeals):** Mail all required documentation (see below for more details) to:
  Claims Payment Reconsideration Department
  UniCare Health Plan of West Virginia, Inc.
  P.O. Box 91
  Charleston, WV 25321-0091
Required Documentation for Claim Payment Disputes
UniCare requires the following information when submitting a claim payment dispute (Reconsideration or Claim Payment Appeal):

- Your name, address, phone number and either your NPI or TIN
- The member’s name and Medicaid ID number
- A listing of disputed claims, including the claim number and the date(s) of service(s):
  - Providers may submit one dispute for multiple claims as long as the issue is similar. Multiple claim disputes that are not similar in nature will be sent back to request separate submissions.
- All supporting statements and documentation

UniCare makes every effort to resolve Claim Payment Disputes. However, if additional information is required to make a determination, we will send a letter identifying the documents we are needing you to send in. You have 30 calendar days to submit the requested information back to us to prevent the denial of untimely filing.

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

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

<table>
<thead>
<tr>
<th>Type of Issue</th>
<th>What Do I Need to Do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rejected Claim(s)</td>
<td>Use the EDI Hotline at 1-800-590-5745 when your claim was submitted electronically but was never paid or was rejected. We’re available to assist you with setup questions and help resolve submission issues or electronic claims rejections.</td>
</tr>
<tr>
<td>RA Requests for Supporting Documentation (Itemized Bills and Invoices)</td>
<td>Submit a Claim Follow-up Form, a copy of your RA and the supporting documentation to: UniCare Health Plan of West Virginia, Inc. Attn: Claims P.O. Box 91 Charleston, WV 25321-0091</td>
</tr>
<tr>
<td>RA Requests for Medical Records</td>
<td>Submit a Claim Follow-up Form, a copy of your RA and the medical records to: UniCare Health Plan of West Virginia, Inc. Attn: Claims P.O. Box 91 Charleston, WV 25321-0091</td>
</tr>
</tbody>
</table>
Need to Submit a Corrected Claim due to Errors or Changes on Original Submission

Submit a Claim Follow-up Form and your corrected claim to:
UniCare Health Plan of West Virginia, Inc.
Attn: Claims
P.O. Box 91
Charleston, WV 25321-0091

Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 180 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to UniCare to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI EOB.

Submission of Coordination of Benefits (COB)/Third-Party Liability (TPL) Information

Submit a Claim Follow-up Form, a copy of your RA and the COB/TPL information to:
UniCare Health Plan of West Virginia, Inc.
Attn: Claims
P.O. Box 91
Charleston, WV 25321-0091

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

Reference: Covered Services
For billing purposes, the following are considered covered services:

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

For a comprehensive list of covered services, access the benefit matrix documents located on the provider webpage at www.unicare.com. Instructions on how to the provider website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website. 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 coverage specifics, please refer to the BMS fee schedules located at www.dhhr.wv.gov/bms/FEES/Pages/default.aspx.

Reference: Clinical Submission Categories
The following is a list of claim categories for which we may routinely require submission of clinical information before or after payment of a claim. If the claim:
• Involves precertification, prior authorization, predetermination or some other form of utilization review, including, but not limited to, claims that are:
  o Pending for lack of precertification or prior authorization
  o Involving medical necessity or experimental/investigative determinations
  o Involving physician-administered drugs that require prior authorization
• Requires certain modifiers, including, but not limited to, modifier 22
• Includes unlisted codes
• Is under review to determine if the service is covered. Benefit determination cannot be made without reviewing medical records. This category includes, but is not limited to, pre-existing condition issues, emergency service/prudent layperson reviews and specific benefit exclusions
• Involves possible inappropriate or fraudulent billing and is under review
• Is the subject of an internal or external audit, including high-dollar claims
• Involves individuals under case or disease management
• Is under appeal or is otherwise the subject of a dispute, including claims being mediated, arbitrated or litigated
Other situations in which clinical information might be routinely requested:

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

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

**Reference: Benefit Codes**
Submit claims with the appropriate benefit code for services, as required:
- For electronic claims, add the benefit code in SBR Loop 2000B, SBRO3.
- For paper claims, add the benefit code in Box 11c on the CMS-1500 claim form.

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

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

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

**Reference: Submitting Pregnancy Notification Reports**
When submitting claims regarding a member’s pregnancy, providers must:
- Submit the *Prenatal Risk Screening Instrument (PRSI)* to UniCare within seven days of the first prenatal visit or as soon as possible. A completed *PRSI* must be emailed to prsi.unicare@anthem.com with “SECURE PRSI” in the subject line or faxed to 1-877-833-5729.
- Use CPT Code 99213, along with the TH modifier when billing UniCare for each prenatal visit. When billing UniCare for an ultrasound or fetal non-stress test, also use modifier 25. Use modifier 25 only if you document a distinct, separately identifiable reason for the visit in the member’s record.
Reference: National Drug Codes
Providers must include national drug codes (NDCs), unit of measurement and quantity of drug on all UniCare claims, including physician-administered drugs. This applies to drugs dispensed in both professional and institutional outpatient settings.

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

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

- NDCs
- Unit of measurement
- Quantity of drug

Please note: The NDC is an 11-digit code on the package or container from which medication is administered.

Reference: Telehealth
The originating site must bill with the appropriate Telehealth originating site code (Q3014), and distant site providers must bill the appropriate Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT)/(HCPCS) code with the appropriate Place of Service code 02. The GT modifier is no longer required to be billed with the service code.

The originating site may bill for an office, outpatient, or inpatient evaluation and management (E&M) service in addition to the Telehealth service and for other Medicaid-covered services the distant site orders, or for services unrelated to the medical problem for which the Telehealth service was requested. The provider may not bill originating site code when the originating site is the home of the member.

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>Problem</td>
<td>Explanation</td>
<td>Resolution</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Authorization Number Missing/Does Not Match Services</strong></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 <em>CMS-1500</em> claim form, use Box 24. On the <em>CMS-1450</em> claim form, use Box 63. Contact the Utilization Management department to revise the service for authorization if changes occur.</td>
</tr>
<tr>
<td><strong>Missing Codes for Required Service Categories</strong></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. Providers must check BMS billing instructions.</td>
</tr>
<tr>
<td><strong>Unlisted Code for Service</strong></td>
<td>Because some procedures or services do not have an associated code, use an unlisted procedure code.</td>
<td>UniCare needs a description of the procedure and medical records in order to calculate reimbursement. DME, prosthetic devices, hearing aids or blood products require a manufacturer’s invoice. For drugs/injections, the J code is required.</td>
</tr>
<tr>
<td><strong>By Report Code for Service</strong></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 J code is required.</td>
</tr>
<tr>
<td><strong>Unreasonable Numbers Submitted</strong></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><strong>Submitting Batches of Claims</strong></td>
<td>Stapling multiple claims together may make the subsequent claims appear to be attachments rather than individual claims.</td>
<td>Clearly identify each individual claim and do not staple to another claim.</td>
</tr>
<tr>
<td>Problem</td>
<td>Explanation</td>
<td>Resolution</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>Nursing Care</td>
<td>Nursing charges are included in the hospital and outpatient care charges. Nursing charges billed separately are considered unbundled charges and are not payable. In addition, UniCare will not pay claims using different room rates for the same type of room to adjust for nursing care.</td>
<td>Do not submit bills for nursing charges.</td>
</tr>
<tr>
<td>Hospital Medicare ID Missing</td>
<td>The Medicare ID number is required to process hospital claims at their appropriate contracted rates.</td>
<td>On the CMS-1450 claim form, hospitals must enter their Medicare ID number in Box 51.</td>
</tr>
</tbody>
</table>

**Reimbursement Policies**

Reimbursement policies serve as a guide to assist you with accurate claim submissions and outline the basis for reimbursement if services are covered by the member’s 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. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using. You are required to use industry-standard, compliant codes on all claims submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the service and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, UniCare may:
- Reject or deny the claim
- Recover and/or recoup claim payment

UniCare reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by provider or state contract language or state, federal requirements or mandates. System logic or set-up may prevent the loading of policies into the claims platforms in the same manner as described; however, UniCare strives to minimize these variations.

**Reimbursement Hierarchy**

Claims submitted for payments must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.
Review Schedules and Updates to Reimbursement Policies
Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a UniCare business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

Medical Coding
The Medical Coding department ensures that correct coding guidelines have been applied consistently through UniCare. Those guidelines include, but are not limited to:
- Correct modifier use
- Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements
- Analysis of codes, code definition and appropriate use

Reimbursement by Code Definition
UniCare allows reimbursement for covered services based on their procedure code definitions or descriptor, as opposed to their appearance under particular CPT categories or sections, or descriptors unless otherwise noted by state or provider contracts or state, federal or CMS contracts and/or requirements. There are eight CPT sections:
1. Evaluation and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services or procedures

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 psychiatric residential treatment facility stay for individuals 21 years of age or older 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 10: BILLING PROFESSIONAL AND ANCILLARY CLAIMS

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

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

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

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

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

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

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

Coding
UniCare uses standardized codes in our effort to process claims in an orderly and consistent manner. HCPCS, sometimes referred to as national codes, provides coding for a wide variety of services. The principal coding levels are referred to as level I and level II:

- **Level I**: CPT codes maintained by the American Medical Association (AMA) and represented by five digits.
- **Level II**: Codes that identify products, supplies and services not included in the CPT codes, such as ambulance supplies and durable medical equipment (DME). Level II codes sometimes are called the alphanumeric codes because they consist of a single alphabetical letter followed by four digits.

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

- The Healthcare Common Procedure Coding System published by the Centers for Medicare and Medicaid Services (CMS). To order, call: **1-800-621-8335**.

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

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

When billing for IHAs, use the following ICD diagnosis codes:

- Z00.121 for children (newborn to 18 years old)
- Z00.00 for adults (19 years and older)

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>82270</td>
<td>Fecal Occult Blood Test (lab procedure code only)</td>
</tr>
<tr>
<td>82465</td>
<td>Total Serum Cholesterol (lab procedure code only)</td>
</tr>
<tr>
<td>84153</td>
<td>PSA (lab procedure code only)</td>
</tr>
<tr>
<td>86580</td>
<td>Tuberculosis (TB) Screening (PPD)</td>
</tr>
<tr>
<td>88150</td>
<td>Pap Smear (lab procedure code only)</td>
</tr>
<tr>
<td>90658</td>
<td>Flu Shot</td>
</tr>
<tr>
<td>90732</td>
<td>Pneumovax</td>
</tr>
</tbody>
</table>
Preventive Medicine Services: New Patient
Preventive medicine services for a new patient start with an IHA. This evaluation includes an age- and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory and diagnostic procedures. Bill for these services using the following codes:

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

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

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

Self-Referable Services
Members may access the following services at any time without preauthorization or referral by their PCP:

- Behavioral Health services
- Family planning, associated services and other sensitive services, supplies, or medications to members of childbearing age to temporarily or permanently prevent or delay pregnancy
- Obstetrics/gynecology (OB/GYN; in-network only from UniCare providers)
- Emergency care
- Vision care

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

Please note: Prior authorization is not required for medically necessary emergency services.
**Emergency:** Any condition manifesting itself by acute symptoms of sufficient severity such that a layperson possessing an average knowledge of health and medicine could reasonably expect that the absence of immediate medical care could:

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

Covered emergency services include:

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

**Family Planning Services**

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

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

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

<table>
<thead>
<tr>
<th>HCPCS/CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1051</td>
<td>Medroxyprogesterone Injection</td>
</tr>
<tr>
<td>11976</td>
<td>Norplant removal</td>
</tr>
<tr>
<td>57170</td>
<td>Diaphragm fitting</td>
</tr>
<tr>
<td>58300</td>
<td>IUD insertion</td>
</tr>
<tr>
<td>58301</td>
<td>IUD removal only</td>
</tr>
<tr>
<td>58615</td>
<td>Occlusion of fallopian tubes by device (for example, band, clip, Falope ring), vaginal or suprapubic approach</td>
</tr>
<tr>
<td>81025</td>
<td>Pregnancy test</td>
</tr>
</tbody>
</table>

**Hospital Readmission Policy**

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

**Immunizations Covered by Vaccines For Children**

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

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

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

The following immunizations are covered under the VFC Program: [www.dhhr.wv.gov/oeps/immunization/providers/Documents/Section%2014/CPT_4212015.pdf](http://www.dhhr.wv.gov/oeps/immunization/providers/Documents/Section%2014/CPT_4212015.pdf)

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90620</td>
<td>Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use.</td>
</tr>
<tr>
<td>90621</td>
<td>Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use.</td>
</tr>
<tr>
<td>90633</td>
<td>Hepatitis A vaccine, pediatric/adolescent dosage, 2 dose schedule for intramuscular use.</td>
</tr>
<tr>
<td>90647</td>
<td>Hemophilus influenza B vaccine (Hib), PRP-OMP conjugate, 3 dose schedule for intramuscular use.</td>
</tr>
<tr>
<td>CPT code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>90648</td>
<td>Hemophilus influenza B vaccine (Hib), PRP-T conjugate, 4 dose schedule, for intramuscular use.</td>
</tr>
<tr>
<td>90649</td>
<td>Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 19, quadrivalent, 3 dose schedule, for intramuscular use.</td>
</tr>
<tr>
<td>90650</td>
<td>Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use.</td>
</tr>
<tr>
<td>90651</td>
<td>Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV)</td>
</tr>
<tr>
<td>90655</td>
<td>Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use.</td>
</tr>
<tr>
<td>90656</td>
<td>Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use.</td>
</tr>
<tr>
<td>90657</td>
<td>Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use.</td>
</tr>
<tr>
<td>90658</td>
<td>Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use.</td>
</tr>
<tr>
<td>90670</td>
<td>Pneumococcal conjugate vaccine, 13 valent, for intramuscular use.</td>
</tr>
<tr>
<td>90672</td>
<td>Influenza virus vaccine, quadrivalent, live, for intranasal use.</td>
</tr>
<tr>
<td>90678</td>
<td>Rotavirus vaccine, pentavalent, 3 dose schedule, lives, for oral use (Rotateq).</td>
</tr>
<tr>
<td>90679</td>
<td>Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use (Rotarix).</td>
</tr>
<tr>
<td>90685</td>
<td>Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use.</td>
</tr>
<tr>
<td>90686</td>
<td>Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use.</td>
</tr>
<tr>
<td>90688</td>
<td>Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use.</td>
</tr>
<tr>
<td>90696</td>
<td>Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 years through 6 years of age, for intramuscular use.</td>
</tr>
<tr>
<td>90698</td>
<td>Diphtheria, tetanus toxoids, acellular pertussis vaccine, hemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-HIB-IPV), for intramuscular use.</td>
</tr>
<tr>
<td>90700</td>
<td>diphtheria, tetanus toxoids, acellular pertussis vaccine (DtaP), when administered to individuals younger than 7 years, for intramuscular use.</td>
</tr>
<tr>
<td>90702</td>
<td>diphtheria and tetanus toxoids (DT), adsorbed when administered to individuals younger than 7 years, for intramuscular use.</td>
</tr>
<tr>
<td>90707</td>
<td>Measles, mumps, and rubella vaccine (MMR), live, for subcutaneous use.</td>
</tr>
<tr>
<td>90710</td>
<td>Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use.</td>
</tr>
<tr>
<td>90713</td>
<td>Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use.</td>
</tr>
<tr>
<td>90714</td>
<td>Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use.</td>
</tr>
<tr>
<td>90715</td>
<td>Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use.</td>
</tr>
<tr>
<td>90716</td>
<td>Varicella virus vaccine, live, for subcutaneous use.</td>
</tr>
<tr>
<td>90723</td>
<td>Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtAP-HepB-IPV), for intramuscular use.</td>
</tr>
</tbody>
</table>
### CPT Code Description

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90732</td>
<td>Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use</td>
</tr>
<tr>
<td>90734</td>
<td>Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use (Menactra).</td>
</tr>
<tr>
<td>90744</td>
<td>Hepatitis B vaccine, pediatric/adolescent dosage; 3 dose schedule, for intramuscular use.</td>
</tr>
</tbody>
</table>

### Modifier Description

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

### Immunization Administration Procedures Covered Under the VFC Program

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

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

### Immunizations Not Covered by Vaccines for Children

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

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

**Please note:** The SL modifier is not required.

### Additional Services during EPSDT Exams

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

### Maternity Services

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

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

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

The following are the billing codes for maternity services:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59409</td>
<td>Vaginal delivery only (with or without episiotomy and/or forceps)</td>
</tr>
<tr>
<td>59412</td>
<td>External cephalic version, with or without tocolysis</td>
</tr>
<tr>
<td>59414</td>
<td>Delivery of placenta (separate procedure)</td>
</tr>
<tr>
<td>59514</td>
<td>Cesarean section only</td>
</tr>
<tr>
<td>59612</td>
<td>Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)</td>
</tr>
</tbody>
</table>
Maternity Services: Codes for Prenatal, Deliveries and Postpartum Services

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

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

Maternity Services: Cesarean Sections

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

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

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

Maternity Services: Newborns

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

- During the month of birth and up to an additional 60 days after the baby is born or
- Until the newborn is assigned his or her own UniCare Medicaid ID number

Also submit the name, date of birth and other pertinent information about the newborn on a Newborn Enrollment Notification Report. To prevent any delay in UniCare coverage for newborns, perform the following:

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

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

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

**Newborns: Circumcision**

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

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

**Billing Members for Services Not Medically Necessary**

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

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

**Private Pay Agreement**

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

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

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

**On-Call Services**

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

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

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

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

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

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

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

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

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

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

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

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

Please note: System edits are in place for both electronic and paper claims. Claims submitted improperly cannot be processed easily and most likely will be returned.
National Drug Codes
Providers must include national drug codes (NDCs), unit of measurement and quantity of drug on all UniCare claims that include physician-administered drugs. This applies to drugs dispensed in both professional and institutional outpatient settings.

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

UniCare will deny professional and outpatient institutional claims containing physician-administered medications for UniCare members if any of the following elements are missing or invalid:
- NDCs (11-digit number on the package or container from which medication is administered)
- Unit of measurement
- Quantity of drug

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

Reimbursement for emergency room services relates to the nature of the emergency diagnosis. There are five CPT procedure codes available for billing emergency room services. The reimbursement is an all-inclusive fee, which is considered to include the following items:
- Use of emergency room
- Routine supplies (such as sterile dressings)
- Minor supplies (bandages, slings, finger braces, etc.)
- Pharmacy charges
- Suture, catheter, and other trays
- IV fluids and supplies
- Routine EKG monitoring
- Oxygen administration and O₂ saturation monitoring

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

UniCare will not reimburse providers for services rendered in an emergency room for the treatment of conditions that do not meet the prudent layperson standard as an emergency medical condition. The exceptions to this requirement are:
- UniCare will reimburse the physician screening fee and facility fee even if the condition is not an emergency
- UniCare will reimburse if either of the following criteria are met:
  - The services were authorized by UniCare
  - The PCP referred the member for treatment
UniCare reviews emergency services claims to determine appropriate use of the emergency room and whether an emergency medical condition existed. At a minimum, both the facility and the physician will receive reimbursement for screening services:

- All ER claims must include clinical documentation.
- ER claims submitted without clinical documentation will be processed at the payment level of CPT code 99282.
- ER claims submitted with clinical documentation and not meeting the prudent layperson standard will be processed at the payment level of CPT code 99282.
- ER claims submitted with clinical documentation and meeting the prudent layperson standard will be processed at the payment level of the CPT code submitted.

Specific coding is required for emergency room billing. Use the following guidelines:

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

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

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

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

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

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

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

Urgent care billing does not apply when the member is admitted and treated for inpatient care following urgent care treatment.
Specific coding is required for urgent care billing. Use the following guidelines:
- Bill each service date as a separate line item.
- Use current ICD principal diagnosis codes, as required, for all services provided in an urgent care setting or designated facility.

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

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

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

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

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

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

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

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

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

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

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

Special billing requirements:
- The facility must be a West Virginia BMS facility.
- Utilization Management department approval is required for all admissions except routine deliveries.
- Observation room, or outpatient billing with an inpatient stay, should be completed on the *CMS-1450* claim form. Complete the “From” box of Form Locator 6 (FL 6) and Form Locator 17 (FL 17) correctly to ensure the claim is processed. Note the following requirements:
  - Ensure the dates reported in (FL 6) and (FL 17) are the same.
  - Verify the charges in (FL 6) and (FL 17) reflect the date the patient was admitted as an inpatient to the hospital.
  - Do not use (FL 6) and (FL 17) to include the date of any observation stay or outpatient charges that occurred prior to inpatient admission. This usage is incorrect and may cause processing delays.
Billing for Hospital Stays of Less Than 24 Hours

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

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

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

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

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

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

Outpatient Laboratory, Radiology and Diagnostic Services

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

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

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

Outpatient Surgical Services

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

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

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

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

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

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

Outpatient Infusion Therapies and Pharmaceuticals
This section covers the following topics:
- Outpatient infusion therapies
- Outpatient infusion pharmaceuticals
Outpatient Infusion Therapies
Billing requirements for outpatient infusion therapy visits apply to each outpatient hospital visit and include, but are not limited to:
- Facility use, including nursing care
- Equipment
- Intravenous solutions, excluding pharmaceuticals
- Kinetic dosing
- Laboratory
- Professional services
- Radiology
- Supplies, including syringes, tubing, line insertion kits, etc.
- Other services incidental to the outpatient infusion therapy visit

Outpatient Infusion Pharmaceuticals
Billing requirements for outpatient infusion pharmaceuticals apply to drugs such as chemotherapy, hydration and antibiotics used during each outpatient infusion therapy visit. An important exception is for blood and blood products, which are billed under the Other Services category.
Specific codes and service dates are required:
- Use revenue codes 026X, 028X, 0331, 0335 or 0940, as required, for each outpatient infusion therapy visit.
- Use revenue code 0940 or 0949 with 36511-36513, 36516 or 36522 CPT/HCPCS codes when billing for therapeutic apheresis claims.
- List each drug for each visit as a separate line item and include the service date.
- Use HCPCS codes, as required, for all pharmaceuticals when:
  - Billed with revenue codes 0250-0252, 0256-0259, or 063X. Include the units with pharmaceutical CPT/HCPCS codes
  - When using an unlisted CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CMS-1450 claim form.

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

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

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

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

Note: Only emergency ambulance services should be billed to UniCare. All nonemergency transportation services are covered through the Fee-for-Service Medicaid program.
Ambulatory Surgical Centers
Most outpatient surgery delivered in an ambulatory surgery center requires prior authorization. Ambulatory surgical centers bill on the CMS-1450 claim form.

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

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

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

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

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

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

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

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

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

**Durable Medical Equipment: Wheelchairs and Wheeled Mobility Aids**
At UniCare, we follow Medicaid guidelines for calculating By Report (customized) wheelchair claims. Claims must include the following:
- Catalogue number
- Item description
- Manufacturer’s name
- Model number

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

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

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

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

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

**Note:** The fee has been removed from CPT code 90999 (unlisted dialysis procedure, inpatient or outpatient). Any future billing of this code requires documentation of the actual services rendered.
Home Infusion Therapy
Certain home infusion therapy codes require prior authorization. When billing for home infusion therapy, use the CMS-1500 claim form and follow these guidelines:
- Obtain prior authorization, as required, from UniCare’s UM department for all infusion therapy.
- Submit all claims within the contracted filing limit.
- Use the appropriate HCPCS codes to bill for all injections.
- Use HCPCS code J3490 along with the NDC for billing injections only if an appropriate injection code does not exist.

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

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

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

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

Additional Billing Resources
The following reference books provide detailed instructions on uniform billing requirements:
- Current Procedural Terminology, published by the American Medical Association (AMA)
- Healthcare Common Procedure Coding System, National Level II (current year)
- International Classification of Diseases (current edition) Volumes 1,2,3 (current year), published by the Practice Management Information Corporation

CMS-1450 Claim Form
All Medicare-approved facilities should bill UniCare using the most up-to-date version of the CMS-1450 claim form. All fields must be completed using standardized code sets. These code sets are used to ensure that claims are processed in an orderly and consistent manner. HCPCS provides codes for a variety of services and consists of Level I and Level II:
- Level I: CPT codes determined by the AMA and represented by five digits.
- Level II: Other codes identifying products, supplies and services not included in the CPT codes, such as ambulance services and DME. Sometimes referred to as the alphanumeric codes because they consist of a single alphabetical letter followed by four digits.

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

CMS-1450 Revenue Codes
CMS-1450 revenue codes are required for all institutional claims.
Institutional Inpatient Coding
For institutional inpatient coding, use the guidelines in the following code manuals:

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

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


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

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

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

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

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

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

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

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

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

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

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

- Complete the UniCare Provider Request for Member Deletion from Primary Care Physician (PCP) Assignment form, located in the Forms and Tools section of the Provider Resources page of our website at www.unicare.com. For directions on how to access the provider 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

State Agency-Initiated Member Disenrollment
Contracted state agencies inform UniCare of membership changes by sending monthly enrollment reports. These reports contain all active membership data and incremental changes to eligibility records. UniCare disenrolls members not listed on the monthly report.
Reasons for disenrollment may include:
- Admission to a long-term care or intermediate care facility beyond the month of admission and the following month
- Change in eligibility status
- County changes
- Death
- Loss of benefits
- Member has other nongovernment or government sponsored health coverage
- Permanent change of residence out of the service area
- Voluntary disenrollment

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

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

**Member 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.

**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 individuals with intellectual disabilities 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 13: GRIEVANCES AND APPEALS

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

Overview
We encourage providers and members to seek resolution of issues through our grievances and appeals process. Verbal complaints and written grievances are tracked and trended, resolved within established timeframes and referred to peer review when needed.

The UniCare grievances and appeals process meets all state of West Virginia requirements and federal laws. The member, or member’s authorized representative with written consent, has a right to be informed about 1) how to obtain a hearing and the representation rules involved; 2) filing grievances and appeals and the requirements and time frames for filing; 3) assistance available with filing grievances and appeals; 4) the toll-free number to file oral grievances and appeals; 5) the right to request continuation of benefits during an appeal or state fair hearing filing although the member may be liable for the costs of any continued benefits if the action is upheld; and 6) any state-determined appeal rights to challenge the failure of the organization to cover a service.

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

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.

An adverse benefit determination is a clear expression by the member, or the member's authorized representative with written consent, following a UniCare decision that the member wants reconsidered or reviewed. Examples of an adverse benefit determination or UniCare’s decisions a member may choose to appeal include but are not limited to:
- Denial or limited authorization of a requested service, including the type and level of service.
- Reduction, suspension or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- For a resident of a rural area with only one MCO, the denial of the member’s request to obtain services outside the network.
- The denial of the member’s request to dispute financial liability

An appeal is a review by UniCare of an adverse benefit determination.

A complaint is the same as a grievance. It’s an expression of dissatisfaction made about UniCare’s decision or services received from UniCare when an informal grievance is filed; some complaints may be subject to appeal. If a distinction cannot be made between a grievance and an inquiry, it is considered a grievance.
An expedited appeal is an appeal when UniCare determines, or the provider indicates in making the request on the member’s behalf or supporting the member’s request, that taking the time for a standard appeal could seriously jeopardize the member’s life or health or ability to attain, maintain or regain maximum function.

A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination as defined below. Examples include but are not limited to:

- The member is unhappy with the quality of the care.
- The doctor the member wants to see does not have a contract with us to provide services to the member.
- The member is not able to receive culturally competent care.
- The member got a bill from a provider for a service that should be covered by UniCare.
- Rights and/or dignity were not respected.
- The member is recommending changes in policies and services.
- Any other access to care issues exist.

The term is also used to refer to the overall system of grievances and appeals handled by UniCare as well as access to the state fair hearing process. The NCQA classifies grievance requests as stages in the appeal process.

The member may file a grievance at any time. An urgent grievance concerns urgent or emergency care services.

A grievance appeal is a formal request for UniCare to review a grievance resolution.

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

The provider or an authorized representative, with the written consent of the member, is able to request an appeal, file a grievance or request a state fair hearing on behalf of a member. Members have a right to ask for support in filing a grievance. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability. Providers may appeal on a member’s behalf related to adverse determinations and nonmedical necessity claims determinations. This can only be done with the member’s written consent.

If a member has a grievance, we would like to hear about the issue either by phone or in writing. Members have the right to file a grievance regarding any aspect of our services. The member or member’s authorized representative (including a provider, with the member’s written consent) can file a grievance or appeal.
Member grievances and appeals include but are not limited to:
- Access to health care services.
- Care and treatment by a provider.
- Issues having with how we conduct business.

UniCare does not discriminate against member or providers for filing a grievance or an appeal on the member’s behalf. In addition, providers are prohibited from penalizing a member in any way for expressing a complaint or filing a grievance.

Please note: UniCare offers an expedited appeal for decisions involving urgently needed care. Standard and expedited appeals are never reviewed by a person who is subordinate to the initial decision-maker.

Members: Filing a Grievance
If a member wants to file a grievance, the member may call the Customer Care Center, write a letter to the Grievance and Appeals department telling us about the problem or fill out a grievance form available on our website. Grievance forms are available wherever members receive their health care, such as at their PCP’s office or at a local UniCare resources office. The member will need to tell us the following:
- Who is part of the grievance
- What happened
- When the incident happened
- Where the incident happened
- Why the member was not happy with the health care services

To file a grievance verbally, the member can call Customer Care Center at 1-800-782-0095. The member must attach documents that will help us investigate the problem and should mail the written grievance form to:
UniCare Health Plan of West Virginia, Inc.
Attn: Grievance and Appeals Department
P.O. Box 91
Charleston, WV 25321-0091

The member does not have to be the person filing a grievance or appeal. Other representatives may include the following:
- Relative
- Guardian
- Conservator
- Attorney
- Member’s PCP or a provider on behalf of the member

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

If the member cannot mail the form or letter, he or she may call UniCare’s Customer Care Center at 1-800-782-0095, 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.
acknowledgement letter includes the receipt date, as well as, the name and contact information of a representative who may be contacted. UniCare will send 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.

The following are guidelines surrounding grievances:
- The Grievances and Appeals department may request medical records or an explanation from the provider(s) involved in the case.
- The Grievances and Appeals department notifies providers of the need for additional information either by phone, mail or fax. Written correspondence to providers includes a signed and dated letter.
- Providers are expected to respond to requests for additional information within 10 days.
- If the Grievances and Appeals department is unable to resolve the grievance within the 30-day period, we will notify the member in writing and explain the reason for the delay. This may extend the case up to an additional 14 days for members. If the time frame is extended, for any extension not requested by the member, UniCare will give the member written notice of the reason for the delay.

Interpreter services and translation of materials into non-English languages and alternative formats are available, at no cost, to support members with the grievance and appeals process.

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

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

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

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).

**Members: Appeals**

An **adverse benefit determination** is a denial, modification or reduction of services based on eligibility, benefit coverage or medical necessity. It can mean any of the following:
• The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
• The reduction, suspension or termination of a previously authorized service
• The denial, in whole or in part, of payment for a service
• The failure to provide services in a timely manner as defined by the state
• The failure of UniCare to act within the time frames in § 438.408(b) (1) (2) regarding the standard resolution of grievances
• For a resident of a rural area with only one MCO: the denial of a member’s request to exercise his or her right, under § 438.52(b) (2) (ii), to obtain services outside the network

UniCare informs members of their grievance, appeal and state fair hearing rights in the member’s enrollment materials. If a member would like to file an appeal, the member, or member’s authorized representative with the member’s consent, must notify us within 60 calendar days of the date on the Notice of Adverse Benefit Determination letter. The request for an appeal may be verbal or written. Verbal appeals must be followed up with in writing. Providers may submit appeals on a member’s behalf with written consent. When a provider, or provider on member behalf, expresses dissatisfaction about an adverse determination involving a clinical issue, the case is handled automatically as an appeal rather than a complaint.

All appeals are acknowledged in writing within five business days of receipt. Appeals are divided into two categories:
• **Standard appeal:** The appropriate process when a member, or his or her representative with written consent, requests that UniCare reconsider the denial of a service or payment for services, in whole or in part. West Virginia’s standard appeal process requires resolution within 30 calendar days of receipt of the written appeal request or within an additional 14 (44 total) calendar days if the member requests an extension, or if UniCare and the DHS determine it’s in the best interest of the member to extend the decision time frame.
• ** Expedited appeals:** An appeal when the amount of time necessary to complete a standard appeal process could jeopardize the member’s life, health or the ability to maintain or regain maximum function. West Virginia’s expedited appeal process requires resolution within 72 hours of receipt of the expedited appeal request. Members may request an expedited appeal by calling our Customer Care Center at 1-800-782-0095.
Members: Resolution of Standard Appeals
Standard appeals are resolved within 30 calendar days of receipt of the initial written or verbal request. Members are notified in writing of the appeal resolution, including their right to further appeal, if any. The decision will be final and the provider will have no further right of appeal related to the action in question.

Members: Extensions
If UniCare is unable to resolve the appeal within the standard 30 days or 72 hours, the resolution time frame for an appeal not related to an ongoing hospitalization or emergency may be extended up to 14 calendar days if:

- The member or representative requests an extension
- UniCare demonstrates there is a need for additional information and the delay is in the member’s interest. UniCare must submit documentation to the West Virginia Bureau for Medical Services (BMS) that the extension is in the member’s best interest. If BMS approves the extension, we immediately provide the member with written notice of the reason for the extension and the date the decision will be made. UniCare will attempt to contact the member by phone to notify him or her of the extension on the resolution of the initial request. This notice will be provided within two calendar days and will include notification of the member’s right to file a grievance if he or she disagrees with the extension. We maintain documentation of any extension request.

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

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

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

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

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.

Members: Other Options for Filing Grievances
If a member is dissatisfied with the appeal decision after exhausting UniCare’s grievances and appeals process, the member has the right to file an appeal with the Bureau for Medical Services (BMS) and request a state fair hearing within 120 calendar days from the date of the notice of action resolution letter. A provider does not have an appeal right with BMS.

Members: State Fair Hearing
UniCare members may request a state fair hearing after they have exhausted all of UniCare’s internal appeals processes. The request must be submitted in writing to the state of West Virginia within 120 calendar days from the date of the notice of action resolution letter:

West Virginia Department of Health and Human Resources
One Davis Square, Suite 100 East
Charleston, WV 25301
Phone: 1-304-558-0684
Fax: 1-304-558-1130

The process is as follows:

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

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.
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, and review and trend cultural and linguistic grievances.

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.

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 at www.unicare.com. For directions on how to the provider website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Provider grievances may be submitted in writing and must include the following:

- Provider’s name
- Date of the incident
- Description of the incident

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

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

A grievance may be filed any time a provider becomes aware of the problem. UniCare will send a written acknowledgement to the provider within five calendar days of receiving a grievance. UniCare may request medical records or an explanation of the issues raised in the grievance by:

- Phone.
- Fax, with a signed and dated letter.
- Mail, with a signed and dated letter.
The timeline for responding to the request for more information is as follows: For standard grievances or appeals, providers must comply with the request for additional information within 10 calendar days of the date that appears on the request.

**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.
CHAPTER 14: CREDENTIALING AND REcredentialing
Customer Care Center phone: 1-800-782-0095
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

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

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

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

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

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

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

CAQH ProView Registration: First Time Users
UniCare providers must have CAQH provider identification number to register and begin the credentialing process. Perform the following steps if you are not registered with CAQH:
1. After you obtain a UniCare provider application packet and submit a current, signed UniCare agreement, UniCare will add your name to the CAQH roster.
2. Go to the CAQH website at https://proview.caqh.org/pr to obtain a CAQH ID number, complete your application and authorize UniCare. Providers who do not have Internet access should contact the CAQH Help Desk at 1-888-599-1771.

Please note: Registration and completion of the online application are free.
CAQH/ProView Registration: Completing the Application Process

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

The following materials will be helpful while completing the ProView online application:

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

After completing the online credentialing application, you will be asked to:

- Authorize access to your information by selecting the checkbox next to UniCare. Or, select the global authorization option.
- Verify your data entry and attestation for accuracy and completeness.
- Upload supporting documents directly to the site. The following are required:
  - 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.

CAQH/ProView Registration: Existing Users

If you have registered your CAQH Provider ID and completed your online application through participation with another health care plan, log on to the ProView database and authorize UniCare to access your information. Follow these steps:
1. Go to: https://proview.caqh.org/pr.
2. In the Sign In section, enter your username and password and select Sign In.
3. Select the Authorize tab located under the CAQH logo.
4. Scroll down to locate UniCare. Select the checkbox next to UniCare or select the global authorization option.
5. Select Save to submit your changes.

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

Additional CAQH Resources
Contact information for the CAQH Help Desk:
Phone: 1-888-599-1771
Operating hours: Monday to Thursday, 7 a.m. to 9 p.m.; Friday, 7 a.m. to 7 p.m.
Email: providerhelp@proview.caqh.org

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

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

Eligible hospital or facility-based specialties include, but are not limited to the following:
- Anesthesiologist
- Emergency room provider
- Hospitalist
- Neonatologist
- Pathologist
- Radiologist

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

Please note: Obtaining a UniCare provider record ID does not activate the Medicaid network automatically. Claims will be processed out-of-network until the provider has applied for network participation and has been approved and activated in the Medicaid network. To complete the contracting process, hospital or facility-based providers must take the steps outlined in the following sections, as appropriate.
Medical Group Adding a Provider
If you are part of a medical group that has a Group Medicaid Agreement and this group is adding you as a facility-based provider with Medicaid: Complete the **Provider Application** and fax the completed application to your local Network Management office for processing.

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

Submit the completed document to your local Network Management office.

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

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

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

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

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

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

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

The following HDOs are not subject to professional conduct and competence review under UniCare’s credentialing program but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:
• Clinical laboratories (Clinical Laboratory Improvement Amendments [CLIA] Certification of Accreditation or CLIA Certificate of Compliance)
• End-stage renal disease (ESRD) service providers (dialysis facilities) (CMS Certification)
• Portable X-ray suppliers (FDA Certification)
• Home infusion therapy when associated with another currently credentialed HDO (CMS Certification)
• Hospice (CMS Certification)
• Federally qualified health centers (FQHC) (CMS Certification)
• Rural health clinics (CMS Certification)

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

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the vice president of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both commercial and Medicaid contracts exist. The chair must be a state or regional lead medical director, or a medical director designee, and the vice-chair must be a lead medical officer or a medical director designee for that line of business not represented by the chair.

In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than ten, external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine), surgery, or behavioral health with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (for example, nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair’s discretion. At least two of the physician committee members must be credentialed for each line of business (for example, commercial, Medicare and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/recredentialing process as needed.

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

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

Practitioners and HDOs are notified they have the right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the credentialing staff will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the process for submission of this additional information, including where it should be sent.

Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner’s credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. On request, the practitioner will be provided with the status of their credentialing or recredentialing application.

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

**Nondiscrimination Policy**

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

**Initial Credentialing**

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

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

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

### A. Practitioners

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

### B. HDOs

<table>
<thead>
<tr>
<th>Verification Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation, if applicable</td>
</tr>
<tr>
<td>License to practice, if applicable</td>
</tr>
<tr>
<td>Malpractice insurance</td>
</tr>
<tr>
<td>Medicare certification, if applicable</td>
</tr>
<tr>
<td>Department of Health survey results, or recognized accrediting organization certification</td>
</tr>
<tr>
<td>License sanctions or limitations, if applicable</td>
</tr>
<tr>
<td>Medicare, Medicaid or FEHBP sanctions</td>
</tr>
</tbody>
</table>
Recredentialing
The recredentialing process incorporates reverification and the identification of changes in the practitioner’s or HDO’s licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner’s or HDO’s professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet UniCare credentialing standards.

During the recredentialing process, UniCare will review verification of the credentialing data as described in the tables under Initial Credentialing, unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements. In addition, UniCare will incorporate performance indicators into the recredentialing cycle. This includes any available information from internal sources such as: satisfaction survey results, UM information, complaints/grievances and other quality improvement activities.

All applicable practitioners and HDOs in the network within the scope of the UniCare credentialing program are required to be recredentialed every three years unless otherwise required by contract or state regulations.

Site Visits
West Virginia regulations: Title 114 Legislative Rule, Insurance Commissioner Series 53, Quality Assurance

6.6. Representatives from the credentialing committee or members of their staff shall make an initial visit to each potential primary care practitioner’s office and to the offices of obstetricians/gynecologists and other high-volume specialists. This process shall include documentation of a structured review of the site and of medical record keeping practices to ensure conformance with the HMO’s standards.

7.e. The recredentialing process shall include an on-site visit to all primary care providers, obstetricians/gynecologists and high-volume specialists and shall involve documentation of a structured review of the site and medical record keeping practices to ensure conformance with HMO standards.

Please note: UniCare does not recognize site accreditation to be used in lieu of an office site review.

Health Delivery Organization
New HDO applicants will submit a standardized application to UniCare for review. If the candidate meets UniCare screening criteria, the credentialing process will commence. To assess whether network HDOs, within the scope of the credentialing program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail in the UniCare Credentialing Program Standards, all network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, UniCare may evaluate the most recent site survey by Medicare or the appropriate state oversight agency performed within the past 36 months for that HDO.

Recredentialing of HDOs occur every three years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in networks or plan programs must submit all required supporting documentation.
On request, HDOs will be provided with the status of their credentialing application. UniCare may request, and will accept, additional information from the HDO to correct incomplete, inaccurate, or conflicting credentialing information. The CC will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

**Ongoing Sanction Monitoring**
To support certain credentialing standards between the recredentialing cycles, UniCare has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:
1. Office of the Inspector General (OIG)
2. Federal Medicare/Medicaid reports
3. Office of Personnel Management (OPM)
4. State licensing boards/agencies
5. Covered individual/customer services departments
6. Clinical Quality Management department (including data regarding complaints of both a clinical and nonclinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Other internal UniCare departments
8. Any other verified information received from appropriate sources

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

**Appeals Process**
UniCare has established policies for monitoring and recredentialing practitioners and HDOs who seek continued participation in one or more of UniCare’s networks or plan programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and UniCare may wish to terminate practitioners or HDOs. UniCare also seeks to treat Network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying 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, probation or revocation
- 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

Participating practitioners and HDOs whose network participation has been terminated due to the practitioner’s suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

**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, state licensing board and legally designated agencies. 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. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

**Credentialing Program Standards**

**I. Eligibility Criteria**

**Health care practitioners:**

Initial applicants must meet all of the following criteria in order to be considered for participation:

A. Must not be currently federally sanctioned, debarred or excluded from participation in Medicare, Medicaid or FEHBP programs

B. Possess a current, valid, unencumbered, unrestricted and nonprobationary license in the state(s) where he/she provides services to covered individuals

C. Possess a current, valid and unrestricted DEA and/or CDS registration for prescribing controlled substance if applicable to his/her specialty in which he/she will treat members; the DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating members. Practitioners who see members in more than one state must have a DEA/CDS registration for each state.

D. Meet the education and training criteria as required by UniCare.

In addition, initial applications must meet the following criteria in order to be considered for participation. UniCare reserves the right, in its reasonable discretion, to waive the board certification or alternative requirement when UniCare determines that there are extenuating or special circumstances that warrant the waiver of such requirement:

A. For MDs, DOs, DPMs and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties [ABMS], American Osteopathic Association [AOA], Royal College of Physicians and Surgeons of Canada [RCPSC], College of Family Physicians of Canada [CFPC], American Board of Foot and Ankle Surgery [ABFAS], American Board of Podiatric Medicine [ABPM], or American Board of Oral and Maxillofacial Surgery [ABOMS]) in the clinical discipline for which they are applying.

B. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
C. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Noncertified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.

D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

E. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
   a. Previous board certification (in one of the approved boards listed above) in the clinical specialty or subspecialty for which they are applying which has now expired AND a minimum of 10 consecutive years of clinical practice
   b. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty
   c. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature, and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in UniCare’s network and the applicant’s professional activities are spent at that institution at least 50% of the time.

Practitioners meeting one of these three alternative criteria (a, b, c) will be viewed as meeting all UniCare education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to UniCare review and approval. Reports submitted by the delegate to UniCare must contain sufficient documentation to support the above alternatives, as determined by UniCare.

For MDs and DOs, the applicant must have unrestricted hospital privileges at either a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), a Healthcare Facilities Accreditation Program (HFAP), Center for Improvement in Healthcare Quality (CIHQ) accredited hospital, or a network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may, at its discretion, deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a network practitioner to provide inpatient care.

II. Criteria for Selecting Practitioners

A. New applicants (credentialing)
   1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions;
   2. Application attestation signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
   3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
   4. No evidence of potential material omission(s) on application;
   5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Covered Individuals;
   6. No current license action;
   7. No history of licensing board action in any state;
8. No current federal sanction and no history of federal sanctions (per System for Award Management [SAM], OIG and OPM report nor on NPDB report);

9. Possess a current, valid, and unrestricted DEA/CDS certificate for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals. The DEA/CDS certificate must be valid in the state(s) in which the practitioner will be treating Covered Individuals. Practitioners who treat Covered Individuals in more than one state must have a valid DEA/CDS certificate for each applicable state. Initial applicants who have NO DEA/CDS certificate will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he has applied for a DEA/CDS certificate, the credentialing process may proceed if all of the following are met:
   a. It can be verified that this application is pending.
   b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS certificate is obtained.
   c. The applicant agrees to notify UniCare upon receipt of the required DEA/CDS certificate.
   d. UniCare will verify the appropriate DEA/CDS certificate via standard sources.
      i. The applicant agrees that failure to provide the appropriate DEA/CDS certificate within a 90-calendar day timeframe will result in termination from the Network.
      ii. Initial applicants who possess a DEA/CDS certificate in a state other than the state in which they will be treating Covered Individuals will be notified of the need to obtain the additional DEA/CDS certificate. If the applicant has applied for additional DEA/CDS certificate the credentialing process may proceed if ALL the following criteria are met:
         (a) It can be verified that this application is pending and,
         (b) The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS certificate is obtained,
         (c) The applicant agrees to notify UniCare upon receipt of the required DEA/CDS certificate,
         (d) UniCare will verify the appropriate DEA/CDS certificate via standard sources;
         (e) The applicant agrees that failure to provide the appropriate DEA/CDS certificate within a ninety (90) calendar day timeframe will result in termination from the Network,
      iii. Office-based practitioners who voluntarily choose to have a DEA/CDS registration that does not include all Controlled Substance Schedules (for example, Schedule, II, III or IV), if that practitioner certifies the following:
         a. controlled substances from these Schedules are not prescribed within his/her scope of practice; and
         b. he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances from these Schedules should it be clinically appropriate; and
         c. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;

11. No history of or current use of illegal drugs or history of or current alcoholism;

12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
13. No gap in work history greater than six (6) months in the past five (5) years with the exception of those gaps related to parental leave or immigration where twelve (12) month gaps will be acceptable.

14. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence. A minimum of the past ten (10) years of malpractice case history is reviewed.

15. Meets credentialing standards for education/training for the specialty(ies) in which practitioner wants to be listed in UniCare’s network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;

16. No involuntary terminations from an HMO or PPO;

17. No “yes” answers to attestation/disclosure questions on the application form with the exception of the following:
   a. investment or business interest in ancillary services, equipment or supplies;
   b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
   c. voluntary surrender of state license related to relocation or nonuse of said license;
   d. an NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria.
   e. non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business);
   f. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the 5-year post-residency training window;
   g. actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion;
   h. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Practitioners who meet all participation criteria for initial or continued participation and whose credentials have been satisfactorily verified by the Credentialing department may be approved by the chair of the CC after review of the applicable credentialing or recredentialing information. This information may be in summary form and must include, at a minimum, practitioner’s name and specialty.

B. Currently participating applicants (recredentialing)
   1. Submission of complete recredentialing application and required attachments that must not contain intentional misrepresentations;
   2. Recredentialing application signed and dated within 180 calendar days of the date of submission to the CC for a vote;
   3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP. If, once a practitioner participates in UniCare’s programs or provider network(s), federal sanction, debarment or exclusion
from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider network(s) as well as UniCare’s other credentialed provider network(s);

4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to members;

5. No new history of licensing board reprimand since prior credentialing review;

6. No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM reports or on NPDB report);

7. Current DEA/CDS registration and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;

8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a network practitioner of similar specialty at a network HDO who provides inpatient care to members needing hospitalization;

9. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;

10. No impairment or other condition that would negatively impact the ability to perform the essential functions in their professional field;

11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;

12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used;

13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;

14. No new (since previous credentialing review) yes answers on attestation/disclosure questions with exceptions of the following:
   a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
   b. Voluntary surrender of state license related to relocation or nonuse of said license;
   c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
   d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business);
   e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post-residency training window;
   f. Actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion;
   g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

15. No QI data or other performance data including complaints above the set threshold. Recredentialed at least every three years to assess the practitioner’s continued compliance with UniCare standards.
Note: It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed network practitioners and HDOs that do not meet one or more of the criteria for recredentialing.

C. Additional participation criteria and exceptions for behavioral health practitioners (nonphysician), nurse practitioners and nurse midwives; all other applicable credentialing and recredentialing criteria needs to be met in addition to these items:

1. Licensed clinical social workers (LCSW and LICSW) or other master level social work license type:
   a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education (CSWE) or the Canadian Association on Social Work Education (CASWE).
   b. Program must have been accredited within three years of the time the practitioner graduated.
   c. Full accreditation is required; candidacy programs will not be considered.
   d. If master’s level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the American Psychological Association (APA) or be regionally accredited by the Council for Higher Education Accreditation (CHEA). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

2. Licensed professional counselor (LPC) and marriage and family therapist (MFT) or other master level license type:
   a. Master’s or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
   b. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
   c. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs (CACREP), or Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) listings. The institution must have been accredited within three years of the time the practitioner graduated.
   d. Practitioners with PhD training as a clinical psychologist can be reviewed. To meet criteria, this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. A practitioner with a doctoral degree in one of the fields of study noted will be viewed as acceptable if the institution granting the degree has regional accreditation from the CHEA.
   e. Licensure to practice independently.
3. **Clinical nurse specialist/psychiatric and mental health nurse practitioner:**
   a. Master’s degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three years of the time of the practitioner’s graduation.
   b. Registered nurse license and any additional licensure as an advanced practice nurse/certified nurse specialist/adult psychiatric nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
   c. Certification by the American Nurses Association (ANA) in psychiatric nursing. This may be any of the following types: clinical nurse specialist in child or adult psychiatric nursing, psychiatric and mental health nurse practitioner, or family psychiatric and mental health nurse practitioner.
   d. Valid, current, unrestricted DEA/CDS certificate, where applicable with appropriate supervision/consultation by a network practitioner as applicable by the state licensing board. For those who possess a DEA certificate, the appropriate CDS certificate is required. The DEA/CDS certificate must be valid in the state(s) in which the practitioner will be treating covered individuals.

4. **Clinical psychologists:**
   a. Valid state clinical psychologist license.
   b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three years of the time of the practitioner’s graduation.
   c. Education/training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a diplomate of the American Board of Professional Psychology.
   d. Master’s level therapists in good standing in the network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the network and will not be subject to the above education criteria.

5. **Clinical neuropsychologist:**
   a. Must meet all the criteria for a clinical psychologist listed in C.4 above and be board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN).
   b. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.
   c. Clinical neuropsychologists, who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      i. Transcript of applicable predoctoral training OR
      ii. Documentation of applicable formal one year post-doctoral training (participation in CEU training alone would not be considered adequate) OR
      iii. Letters from supervisors in clinical neuropsychology (including number of hours per week) OR
      iv. Minimum of five years’ experience practicing neuropsychology at least 10 hours per week
6. **Licensed psychoanalysts:**
   a. This applies only to practitioners in states that license psychoanalysts.
   b. Practitioners will be credentialed as a licensed psychoanalyst if they aren’t otherwise credentialed as a practitioner type, as detailed in the credentialing policy (e.g., psychiatrist, clinical psychologist, licensed clinical social worker).
   c. The practitioner must possess a valid psychoanalysis state license.
      i. The practitioner shall possess a master’s or higher degree from a program accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Postsecondary Education, American Psychological Association (APA), Council for Accreditation of Counseling & Related Educational Programs (CACREP) or the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) listings. The institution must have been accredited within three years of the time the practitioner graduates.
      ii. The practitioner shall complete a program in psychoanalysis that is registered by the licensing state as licensure-qualifying, accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting agency, or determined by the licensing state to be the substantial equivalent of such a registered or accredited program.
         1. A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the licensing state determines that it:
            a. Prepares individuals for the professional practice of psychoanalysis
            b. Is recognized by the appropriate civil authorities of that jurisdiction
            c. Can be appropriately verified
            d. Is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure-qualifying or accredited program
      2. The practitioner must meet the minimum supervised experience requirement for licensure as a psychoanalyst, as determined by the licensing state.
      3. The practitioner must meet the examination requirements for licensure, as determined by the licensing state.

D. **Process, requirements and verification for** nurse practitioners:
   1. The nurse practitioner applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
   2. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the licensing agency or certification board does not verify the highest level of education, the education will be primary source verified in accordance with policy.
3. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

4. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal UniCare procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.

5. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
   a. Certification program of the American Nurse Credentialing Center (www.nursecredentialing.org), a subsidiary of the American Nursing Association (http://www.nursingcertification.org); or
   b. American Academy of Nurse Practitioners Certification Program (https://www.aanpcert.org); or
   c. National Certification Corporation (https://www.nccwebsite.org); or
   d. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse (CPN) Practitioner (note: CPN is not a nurse practitioner) (https://www.pncb.org/pncb-exams); or
   e. Oncology Nursing Certification Corporation (ONCC) Advanced Oncology Certified Nurse Practitioner (AOCNP®) only (http://oncc.org); or
   f. American Association of Critical Care Nurses (https://www.aacn.org/certification/verify-certification); Adult Care Nurse Practitioner (ACNPC). This certification must be active and primary source verified; ACNPC-AG — Adult Gerontology Acute Care. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by UniCare is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

6. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.

7. The NP applicant will undergo the standard credentialing processes outlined in UniCare’s Credentialing Policies (“Credentialing Policies” or Credentialing Policy). NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three (3) years, and continuous sanction and performance monitoring upon participation in the network.

8. Upon completion of the credentialing process, the NP may be listed in UniCare’s provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

NPs will be clearly identified:
- On the credentialing file;
At presentation to the CC; and
Upon notification to Network Services and to the provider database.

E. Process, requirements and verifications for certified nurse midwives:
1. The certified nurse midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
2. The required educational/training will be at a minimum required for licensure as a RN with subsequent additional training for licensure as a CNM by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
3. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
4. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal UniCare procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
5. All CNM applicants will be certified by either:
   a. The National Certification Corporation for OB/GYN and Neonatal Nursing; or
   b. The American Midwifery Certification Board, previously known as the American College of Nurse Midwives.
This certification must be active and primary source verified. If the state licensing board primary source verifies one of these certifications as a requirement for licensure, additional verification by UniCare is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.
6. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO or HFAP accredited hospital, or a network hospital previously approved by the committee, or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a level II review. Should the CNM provide only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/GYN.
7. The CNM applicant will undergo the standard credentialing process outlined in UniCare’s Credentialing Policies. CNMs are subject to all the requirements of these Credentialing Policies including (but not limited to): the requirement for committee review for level II applicants; recredentialing every three years; and continuous sanction and performance monitoring on participation in the network.
8. Upon completion of the credentialing process, the CNM may be listed in UniCare’s provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

9. CNMs will be clearly identified as such:
   - On the credentialing file.
   - At presentation to the CC.
   - On notification to Network Services and to the provider database.

F. Process, requirements and verifications for physician’s assistants (PA):

1. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.

2. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.

3. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid, will be notified of this and the applicant will be administratively denied.

4. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal UniCare procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.

5. All PA applicants will be certified by the National Commission on Certification of Physician’s Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by UniCare is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a level II according to geographic Credentialing Policy 8 and submitted for individual review by the CC.

6. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.

7. The PA applicant will undergo the standard credentialing process outlined in UniCare’s Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies, including (but not limited to): committee review of level II files failing to meet predetermined criteria; recredentialing every three years; and continuous sanction and performance monitoring on participation in the network.

8. Upon completion of the credentialing process, the PA may be listed in UniCare provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

9. PA's will be clearly identified such:
   - On the credentialing file.
- At presentation to the CC.
- On notification to Network Services and to the provider database.

III. HDO Eligibility Criteria
All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, UniCare may evaluate the most recent site survey by Medicare or the appropriate state oversight agency performed within the past 36 months. Nonaccredited HDOs are subject to individual review by the CC and will be considered for covered individual access need only when the CC review indicates compliance with UniCare standards, and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality, care or patient safety. HDOs are recredentialed at least every three years to assess the HDO’s continued compliance with UniCare standards.

A. General criteria for HDOs:
1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to covered individuals (the license must be in good standing with no sanctions)
2. Valid and current Medicare certification
3. Must not be currently debarred or excluded from participation in any Medicare, Medicaid of FEHBP programs
   ○ Note: If, once an HDO participates in UniCare’s programs or provider network(s), exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification the HDO will become immediately ineligible for participation in the applicable government programs or provider network(s), as well as UniCare’s other credentialed provider network(s).
4. Liability insurance acceptable to UniCare

If not appropriately accredited, the HDO must submit a copy of its CMS or state site survey for review by the CC, to determine if UniCare’s quality and certification criteria standards have been met.

B. Additional participation criteria for HDOs by provider type:

<table>
<thead>
<tr>
<th>MEDICAL FACILITIES</th>
<th>Acceptable accrediting agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care hospital</td>
<td>CIQH, CTEAM, HFAP, DNV/NIAHO, TJC</td>
</tr>
<tr>
<td>Ambulatory surgical center</td>
<td>AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC</td>
</tr>
<tr>
<td>Birthing center</td>
<td>AAAHC, CAB, TJC</td>
</tr>
<tr>
<td>Home health care agency (HHA)</td>
<td>ACHC, CHAP, CTEAM, DNV/NIAHO, TJC</td>
</tr>
<tr>
<td>Home infusion therapy (HIT)</td>
<td>ACHC, CHAP, CTEAM, HQAA, TJC</td>
</tr>
<tr>
<td>Skilled nursing facility/nursing homes</td>
<td>BOC INT’L, CARF, TJC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BEHAVIORAL HEALTH (BH)</th>
<th>Acceptable accrediting agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care hospital — psychiatric disorders</td>
<td>CTEAM, DNV/NIAHO, TJC, HFAP</td>
</tr>
<tr>
<td>Adult family care home (AFCH)</td>
<td>ACHC, TJC</td>
</tr>
<tr>
<td>Adult foster care</td>
<td>ACHC, TJC</td>
</tr>
<tr>
<td>Community mental health center (CMHC)</td>
<td>AAAHC, CARF, CHAP, COA, TJC</td>
</tr>
<tr>
<td>Crisis stabilization unit</td>
<td>TJC</td>
</tr>
<tr>
<td>Intensive family intervention services</td>
<td>CARF</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Intensive outpatient — mental health and/or substance abuse</td>
<td>ACHC, DNV/NIAHO, TJC, COA, CARF</td>
</tr>
<tr>
<td>Outpatient mental health clinic (includes licensed BH clinics)</td>
<td>HFAP, TJC, CARF, COA, CHAP</td>
</tr>
<tr>
<td>Partial hospitalization/day treatment — psychiatric disorders and/or substance abuse</td>
<td>CARF, DNV/NIAHO, HFAP, TJC</td>
</tr>
<tr>
<td>Residential treatment center (RTC) — psychiatric disorders and/or substance abuse</td>
<td>DNV/NIAHO, TJC, HFAP, CARF, COA</td>
</tr>
</tbody>
</table>

**REHABILITATION**

<table>
<thead>
<tr>
<th>Facility type (BH care)</th>
<th>Acceptable accrediting agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute inpatient hospital — detoxification only facilities</td>
<td>DNV/NIAHO, HFAP, TJC, CTEAM</td>
</tr>
<tr>
<td>Behavioral health ambulatory detox</td>
<td>CARF, TJC</td>
</tr>
<tr>
<td>Methadone maintenance clinic</td>
<td>CARF, TJC, COA</td>
</tr>
<tr>
<td>Outpatient substance abuse clinics</td>
<td>CARF, TJC</td>
</tr>
</tbody>
</table>
Overview
This chapter outlines UniCare’s standards for timely and appropriate access to quality health care. Following guidelines set by the National Committee for Quality Assurance (NCQA), the American College of Obstetricians and Gynecologists (ACOG), and the West Virginia Bureau for Medical Services (BMS), these standards help ensure that medical appointments, emergency services and continuity of care for our members are provided fairly, reasonably and within specific time frames.

We recognize that cultural and linguistic barriers may affect our members’ ability to understand or comply with certain instructions or procedures. To break through those barriers and ensure that our access standards can be met, we encourage providers to take advantage of UniCare’s Cultural Competency Training and Cultural and Linguistic Toolkit called Caring for Diverse Populations. We have included an introduction to this training in Chapter 24: Cultural Diversity and Linguistic Services. Locate the complete training program and toolkit in the Health Education section on the Provider Resources page of our website at www.unicare.com and select Cultural Competency Training and Caring For Diverse Populations. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

UniCare encourages providers to attend training in an effort to promote sensitivity to the special needs of the Medicaid population. UniCare supports continuous education through webinars, town hall meetings and provider orientations.

UniCare monitors provider compliance with access to care standards on a regular basis. Failure to comply may result in corrective action.

General Appointment Scheduling
PCPs and specialists must make appointments for members from the time of request according to the following guidelines:

<table>
<thead>
<tr>
<th>Nature of visit</th>
<th>Appointment standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency examinations</td>
<td>Immediate access during office hours</td>
</tr>
<tr>
<td>Urgent examinations</td>
<td>Within 48 hours of request</td>
</tr>
<tr>
<td>Nonurgent “sick visits”</td>
<td>Within 72 hours of request</td>
</tr>
<tr>
<td>Nonurgent routine examinations*</td>
<td>Within 21 business days of member’s request</td>
</tr>
<tr>
<td>Adult baseline and routine physical</td>
<td>Within 30 business days</td>
</tr>
<tr>
<td>Specialty care examinations</td>
<td>Within 10 business days of request for routine referrals; within 24 hours for urgent referrals</td>
</tr>
</tbody>
</table>

* Exceptions are permitted for routine cases, other than clinical preventive services, when PCP capacity is temporarily limited.

Services for Members
UniCare strongly recommends that PCPs perform an initial health assessment (IHA) and preventive care assessment with new members.
Please note: An IHA is not needed if the member is an existing patient of the PCP group but new to UniCare. In addition, follow-up is not needed if there is an established medical record that shows baseline health status. This record should include sufficient information for the PCP to understand the member’s health history and to provide treatment recommendations as needed. Transferred medical records meet the recommendations for an IHA if a completed health history is included.

<table>
<thead>
<tr>
<th>Nature of visit</th>
<th>Appointment standards</th>
</tr>
</thead>
</table>
| IHAs               | Newborns: Within 30 days of birth
|                    | Children (ages 0-18): Within 60 days of enrollment
|                    | Adults (ages 18 and older): Within 90 days of enrollment                                |
| Preventive care visits | According to the American Academy of Pediatrics (AAP) periodicity schedule found within the preventive health care guidelines |

**Behavioral Health Access to Care Standards**

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

<table>
<thead>
<tr>
<th>Behavioral health</th>
<th>Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Emergent: Immediately</td>
</tr>
<tr>
<td>2.</td>
<td>Emergent, Non-Life-Threatening/Crisis Stabilization; Within six hours of request.</td>
</tr>
<tr>
<td>3.</td>
<td>Urgent: Within 48 hours of referral/request</td>
</tr>
<tr>
<td>4.</td>
<td>Outpatient treatment by a BH provider (routine visits) within 10 business days:</td>
</tr>
<tr>
<td></td>
<td>a. Outpatient following discharge from an IP Hospital: Within 7 days of discharge.</td>
</tr>
<tr>
<td></td>
<td>b. Outpatient BH Exams: within 14 business days of request</td>
</tr>
<tr>
<td></td>
<td>c. Members should be seen within 45 minutes of their scheduled appointment time (emergencies excluded)</td>
</tr>
<tr>
<td></td>
<td>d. 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</td>
</tr>
</tbody>
</table>

**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.
**Prenatal and Postpartum Visits**
Providers must make prenatal and postpartum appointments for members from the time of request according to the following guidelines:

<table>
<thead>
<tr>
<th>Nature of visit</th>
<th>Appointment standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>First trimester</td>
<td>Within 14 calendar days of request</td>
</tr>
<tr>
<td>Second trimester</td>
<td>Within 7 calendar days of request</td>
</tr>
<tr>
<td>Third trimester</td>
<td>Within 3 business days of request or immediately if an emergency</td>
</tr>
<tr>
<td>High-Risk pregnancy</td>
<td>Within 3 business days of request or immediately if an emergency</td>
</tr>
<tr>
<td>Postpartum examination</td>
<td>Between 3 and 8 weeks after delivery</td>
</tr>
</tbody>
</table>

**Missed Appointment Tracking**
When a member misses an appointment, providers must do the following:
- Document the missed appointment in the member’s medical record.
- Make at least three attempts to contact the member to determine the reason for the missed appointment.
- Provide a reason in the member’s medical record for any delays in performing an examination, including any refusals by the member.

**After-Hours Services**
Our members have access to quality health care 24/7. This means that PCPs must have a system in place to ensure members may call after-hours with medical questions or concerns. UniCare monitors PCP compliance with after-hours access standards on a regular basis. We recommend that PCPs advise their answering services to participate in any after-hours monitoring. Failure to comply may result in corrective action. PCPs must adhere to the answering service and answering machine protocols defined in the following sections.

**Answering Service**
Answering service or after-hours personnel must:
- Ask the member if the call is an emergency. In the event of an emergency, direct the member to dial 911 immediately or proceed directly to the nearest hospital emergency room.
- Forward nonemergency member calls directly to the PCP or on-call provider or instruct the member that the provider will be in contact within 30 minutes.
- Have the ability to contact a telephone Interpreter to assist members with language barriers.
- Return all calls.

Members may call the 24/7 NurseLine any time of the day or night to speak to a registered nurse. 24/7 NurseLine nurses provide health information and options for accessing care, including emergency services, if appropriate.

**Answering Machines**
Answering machine messages:
- May be used when provider office staff or an answering service is not immediately available.
- Must instruct members with emergency health care needs to dial 911 or proceed directly to the nearest hospital emergency room.
- Must provide instructions on how to contact the PCP or on-call provider in a nonemergency situation.
• Must provide instructions in English, Spanish and any other language appropriate to the PCP’s practice.

We offer the following suggested text for answering machines:

“Hello, you have reached [insert Physician office name]. If this is an emergency, hang up and dial 911 or go to the nearest hospital emergency room. If this is not an emergency and you have a medical concern or question, please call [insert contact phone or pager number]. You will receive a return call from the on-call physician within [time frame].”

Please note: UniCare has implemented a system to report difficulties experienced with the 24/7 NurseLine, emergency care systems, or protocol failures. To report failures, contact the Customer Care Center at 1-800-782-0095. Corrective action plans will be requested from contracted network hospitals with emergency departments that fail to meet the department/emergency room protocols.

Please note: UniCare prefers that PCPs use a UniCare-contracted, in-network provider for on-call services. When this is not possible, the PCP must use his or her best efforts to ensure the on-call provider abides by the terms of the UniCare provider contract.

**Continuity of Care**

UniCare provides continuity of care for members with qualifying conditions when health care services are not available within the network or when the member or provider is in a state of transition.

**Qualifying condition:** A medical condition that may qualify a member for continued access to care and continuity of care. These conditions include, but are not limited to:

• Acute conditions (cancer, for example)
• Degenerative and disabling conditions or diseases caused by a congenital or acquired injury or illness requiring a specialized rehabilitation program or a high level of service, resources or coordination of care in the community
• Newborns, who are covered retroactive to the date of birth
• Organ transplant or tissue replacement
• Pregnancy, with 12 weeks or less remaining before the expected delivery date, through immediate postpartum care
• Scheduled inpatient/outpatient surgery that was approved and/or precertified through the applicable BMS process
• Serious chronic conditions (hemophilia, for example)
• Terminal illness

States of transition may be when the member is:

• Newly enrolled
• Moving out of the service area
• Disenrolling from UniCare to another health plan
• Exiting UniCare to receive excluded services
• Hospitalized on the effective date of transition
• Transitioning through behavioral health services
• Undergoing the West Virginia Preadmission Screening/Resident Review Screening for long-term care placement
Scheduled for appointments within the first month of plan membership with specialists. These appointments must have been scheduled prior to the effective date of membership.

A state of transition is also applicable when the provider’s contract terminates.

UniCare providers help ensure continuity and coordination of care through collaboration. This includes the confidential exchange of information between PCPs and specialists as well as behavioral health providers. In addition, UniCare coordinates care when the provider’s contract has been discontinued to facilitate a smooth transition to a new provider.

Providers must maintain accurate and timely documentation in the member’s medical record, including, but not limited to:

- Consultations
- Prior authorizations
- Referrals to specialists
- Treatment plans

All providers share responsibility in communicating clinical findings, treatment plans, prognosis and the member’s psychosocial condition as part of the coordination process. Utilization 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.

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.

Provider Contract Termination

UniCare will arrange for continuity of care for members affected by a provider whose contract has terminated. The provider must notify members 60 days prior to the final date of termination. A terminated provider who is actively treating members must continue treatment for a period of at least 90 days after the date on which notice is given.

After UniCare receives a provider’s notice to terminate a contract, we will make our best effort to notify all impacted members. A letter will be sent at least 30 days in advance to inform the affected members about:

- The impending termination of the provider
- The member’s right to request continued access to care
- The Customer Care Center’s phone number. The Customer Care Center can make PCP changes and/or forward referrals to Case Management for continued access to care consideration

Members under the care of specialists may submit requests for continued access to care, including continued care after the transition period. Members should contact the Customer Care Center at 1-800-782-0095.
**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, authorized and covered services until that regimen of care is completed. Then, the member’s records, clinical information and care are transferred to a UniCare provider.

Payment to out-of-network providers is made within the same time period required for providers within the network. In addition, we will comply with out-of-network provider reimbursement rules as adopted by the BMS. However, we are not obligated to reimburse the member’s existing out-of-network providers for ongoing care if it has been greater than:

- 90 days after the member enrolled in UniCare
- Nine months after the member enrolled in UniCare when, at the time of enrollment in our plan, the member was diagnosed with and receiving treatment for a terminal illness and remains enrolled in UniCare

All new enrollees receive the Member Handbook and Evidence of Coverage (EOC) membership information in their enrollment packets, which provides information regarding members’ rights to request continuity of care.

**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.

**Services Not Available Within Network**

UniCare will provide members with timely and adequate access to out-of-network services for as long as those services are necessary and not available within the network. However, UniCare is not obligated to provide members with access to out-of-network services if such services become available from a network provider.

When a provider refers a member to another provider for additional treatment or services, the referring provider must forward notification of his/her NPI and the member’s eligibility. UniCare has streamlined this process by providing a *Record of Referral to Specialty Care* form, on our website at www.unicare.com. For directions on how to access the *Provider Resources* page of our website, please see *Chapter 1: How to Access Information, Forms and Tools on Our Website*.

The referring PCP and the specialist perform the following:

- The PCP completes and faxes the form to the specialist, notifying the specialist of the PCP’s NPI.
- If the referring PCP does not provide the NPI, the specialist is responsible for contacting the PCP’s office to obtain the NPI.
• The member must be made aware that the provider they are being referred to is in-network or out-of-network.

Please note: Referrals are valid for as long as the member is under the care of the specialist.

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, when authorized.

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.

Nonemergency Transportation
Nonemergency transportation is not a covered service for UniCare. All nonemergency transportation is covered by the state of West Virginia through its fee-for-service program. Visit the West Virginia Bureau for Medical Service website for additional information at www.dhhr.wv.gov/bms/Pages/default.aspx.

Emergency Dental Services for Adults
When a member has an accident and the treatment is the first repair of an injury to the jaw, sound natural teeth, mouth or face, UniCare covers the initial dental work and oral surgery, including anesthesia and drugs, for services provided in the following settings:
• Outpatient
• Doctor’s office
• Emergency care
• Urgent care

The services are limited to the care needed to give proper treatment. Injury as a result of chewing or biting is not considered an accidental injury. Initial dental work refers to services provided within 48 hours of the injury, or as soon as possible. Covered services include all exams and treatment to complete the repair, such as:
• Anesthesia
- Lab tests
- Mandibular/maxillary reconstruction
- Oral exams
- Oral surgery
- Prosthetic services
- Restorations
- X-rays
Overview
At UniCare, our goal is to provide quality health care to the right member, at the right time, in the appropriate setting. To achieve this goal, PCPs, specialists and ancillary providers must fulfill your roles and responsibilities with the highest integrity. We rely on your extensive health care education, experience, and dedication to our members, who look to you to get well and stay well.

As required by 42 CFR 438.602(b), all participating providers that order, refer or render covered services must enroll with the Department through the fiscal agent as a Medicaid provider. Enrollment with the Department does not obligate participating providers to offer services under the Fee-for-Service delivery system. UniCare is not required to contract with a provider enrolled with the Department that does not meet our credentialing or other requirements.

Primary Care Providers
PCPs are the principle point of contact for our members. The PCP’s role is to provide members with a medical home, the member’s first stop in the health care process and a centralized hub for a wide variety of ongoing health care needs. UniCare furnishes each PCP with a current list of enrolled members assigned to that PCP. The PCP’s role is to:

- Coordinate members’ health care 24 hours a day, 7 days a week
- Develop members’ care and treatment plans, including preventive care
- Maintain members’ current medical records, including documentation of all services provided by the PCP and any specialty or referral services
- Adhere to wait times, as outlined within the provider contract and the provider manual
- Referrals for specialty care and other medically necessary covered services, both in-network and out-of-network, consistent with UniCare's utilization management policies
- Coordinate with outpatient clinical services
- Provide complete information about proposed treatments and prognosis for recovery to our members or their representatives
- Facilitate interpreter services by presenting information in a language that our members or their representatives can understand
- Ensure that members’ medical and personal information is kept confidential, as required by state and federal laws
- Obtain signed consent before providing care
- Adhere to UniCare and West Virginia Medicaid managed care program policies
- Facilitate adherence to the EPSDT periodicity schedule

The PCP’s scope of responsibilities includes providing or arranging for:
- Routine and preventive health care services
- Emergency care services
- Behavioral health services
- Hospital services
- Ancillary services
- Interpreter services
• Referrals for specialty services
• Coordination with outpatient clinical services, such as therapeutic, rehabilitative or palliative services

Please note: Services should be provided without regard to race, religion, gender, gender identity, sexual orientation, color, national origin, age or physical/behavioral health status.

UniCare keeps providers up-to-date with detailed member information. We also furnish each PCP with a current list of assigned members and provide medical information about the members’ potential health care needs. Providers may use this information to provide care and coordinate services more effectively. PCPs should provide services only to those UniCare members who have chosen you as their PCP. Verify that a member is assigned to you by using the following methods:

• Call UniCare’s Customer Care Center at 1-800-782-0095:
  o Use the Interactive Voice Response (IVR) system
  o Speak to a Customer Service representative
• Go to https://www.availity.com and select Login to enter the secure provider portal. Then, log in to the provider online reporting tool to view the monthly PCP rosters.

You may experience delays in claims payments if you treat members who are not assigned to you on the date of service. If you must provide services to a UniCare member not assigned to you, obtain prior authorization first. If you are a noncontracted provider, you must obtain prior authorization before treating UniCare members.

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 health care 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.

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.

Procedure for Closing a PCP Panel
A PCP who no longer wishes to accept new members may submit a written notification to UniCare to close his or her panel. In this situation, any new member who is not an established patient cannot select a PCP with an approved closed panel. A PCP may re-open a “closed” panel by submitting a written notification to UniCare. When a member request a PCP with a “closed” panel, the Customer Care Associate will notify the member of the physician’s panel status. The Customer Care Associate will contact the physician to see if an exception is allowed to accept the member, then facilitating an override to assign member on a case by case basis.

Referrals
PCPs coordinate and make referrals to specialists, ancillary providers and community services. Providers should refer members to network facilities and providers. When network facilities and providers are not available, providers should follow the appropriate process for requesting out-of-network referrals.

Please note: Specialty referrals to in-network providers do not require prior authorization.

All PCPs must perform the following with regard to referrals:
• Help members schedule appointments with other health care providers, including specialists.
• Track and document appointments, clinical findings, treatment plans and care received by members referred to specialists or other health care providers.
• Refer members to health education programs and community resource agencies, when appropriate.
• Coordinate with the Women, Infants and Children (WIC) program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin.
• Coordinate with the local tuberculosis (TB) control program to ensure that all members with confirmed or suspected TB have a contact investigation and receive directly observed therapy (DOT).
• Report to the West Virginia Bureau for Medical Services (BMS) or the local TB control program any member who is noncompliant, drug resistant, or who is or potentially may become a public health threat.
• Screen and perform evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.
Out-Of-Network Referrals
We recognize that an out-of-network referral may be justified at times. UniCare’s Utilization Management (UM) department will review requests and authorize out-of-network services based on medical necessity and the availability of in network services. For assistance, contact the UM department at 1-866-655-7423. Hours of operation are Monday to Friday, 8 a.m. to 5 p.m.

Interpreter Services
Providers must notify members of the availability of interpreter services from UniCare. Providers should strongly discourage the use of friends and family members, especially children, acting as interpreters. Multilingual staff should carefully self-assess their non-English language speaking and comprehension skills prior to interpreting on the job. You may find the current recommended employee language skills self-assessment tool on our website at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

For those instances when you cannot communicate with a member due to language barriers, interpreter services are available at no cost to you or the member. Face-to-face Interpreters for members needing language assistance, including American Sign Language, are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required.
- To request interpreter services, call UniCare’s Customer Care Center at 1-800-782-0095.
- To request interpreter services after hours or TTY and Relay services, call the 24/7 NurseLine at 1-888-850-1108.

Initial Health Assessment
PCPs are should review their monthly eligibility list provided by UniCare and determine which members are newly enrolled since the last report. PCPs should proactively contact their assigned members to make an appointment for an initial health assessment (IHA) within 90 days of enrollment. The PCP’s office is responsible for making contact with assigned members and documenting all attempts to do so. Members’ medical records must reflect the reason for any delays in performing the IHA, including any refusals by the member to have the exam.

Transitioning Members between Medical Facilities and Home
When medically indicated, PCPs initiate or assist with the discharge or transfer of members:
- From an inpatient facility to the appropriate skilled nursing or rehabilitation facility, or to the member’s home
- From an out-of-network hospital to an in-network hospital, or to the member’s home with home health care assistance (within benefit limits)

The coordination of member transfers from noncontracted, out-of-network facilities to contracted, in-network facilities is a priority that may require the immediate attention of the PCP. To obtain assistance, contact UniCare’s UM department at 1-866-655-7423.

Noncovered Services
All PCPs must inform members of the costs associated with noncovered services prior to rendering the noncovered services. For more information, call our Customer Care Center at 1-800-782-0095. Also refer to the Private Pay Agreement section of this manual.
Specialists
Specialists, licensed with additional training and expertise in a specific field of medicine, supplement the care given by PCPs. Specialists are charged with the same responsibilities as PCPs, including the responsibility of ensuring that prior authorization has been obtained before rendering services. Access to specialty care begins when the PCP refers a member to a specialist for medically necessary conditions beyond the PCP’s scope of practice. Specialists diagnose and treat conditions specific to their area of expertise.

Please note: Specialty care is limited to UniCare benefits.

The following guidelines are in place for specialists:
- For urgent care, the specialist should see the member within 24 hours of receiving the request.
- For routine care, the specialist should see the member within two weeks of receiving the request.

In some cases, a member may self-refer to a specialist. These cases include, but are not limited to:
- Family planning and evaluation
- Diagnosis, treatment and follow-up of sexually transmitted infections (STIs)
- Initial behavioral health evaluation

For some medical conditions, the specialists should be the PCP. In these instances, the specialist must be able to demonstrate the ability to provide comprehensive primary care. Members may request the specialist be assigned as the PCP if the member:
- Has a chronic illness
- Has a disabling condition
- Is a child with special health care needs

Hospital Scope of Responsibilities
PCPs refer members to UniCare-contracted network hospitals for medically necessary conditions beyond the PCP’s scope of practice. Hospital care is limited to plan benefits. Hospital providers diagnose and treat conditions specific to their area of expertise. Hospital responsibilities include:
- Notification of admission and services
- Notification of preservice review decision

Refer to the following sections for specific information.

Notification of Admission and Services
The hospital must notify UniCare or the review organization of an admission or service at the time the Member is admitted or the service is rendered. If the member is admitted or a service is rendered on a day other than a business day, the hospital must notify UniCare the morning of the next business day.

Notification of Preservice Review Decision
The utilization management guidelines and the hospital agreement require that a hospital receive notice of a preservice review determination at the time of a scheduled admission or service. If this does not occur, the hospital should contact UniCare and request the status of the decision.
Any admission or service requiring preservice review that has not received the appropriate review will be subject to post-service review denial. Generally, the provider is required to perform all preservice review functions with UniCare. Before services are rendered, the hospital must ensure the preservice review has been performed. If the preservice review has not been performed, the hospital risks post-service denial.

**Ancillary Scope of Responsibilities**

PCPs and specialists refer members to plan-contracted network ancillary providers for medically necessary conditions beyond the PCP’s or specialist’s scope of practice. Ancillary providers diagnose and treat conditions specific to their area of expertise. Ancillary care is limited to plan benefits. We have a wide network of participating health care providers and facilities. All services offered by the health care provider, and for which the health care provider is responsible, are listed in the ancillary agreement.

**Responsibilities Applicable to All Providers**

The following responsibilities, described below, are applicable to all UniCare providers include:

- After-hours services
- Disenrollees
- Eligibility verification
- Collaboration
- Confidentiality
- Continuity of care
- Licenses and certifications
- Mandatory reporting of abuse
- Medical records standards and documentation
- Office hours
- Open clinical dialog/affirmative statement
- Oversight of non-physician practitioners
- Preservice reviews
- Prohibited activities
- Provider contract terminations
- Termination of ancillary provider/patient relationship
- Updating provider information

**Office Hours**

To maintain continuity of care, providers’ office hours must be clearly posted and members must be informed about the providers’ availability at each site. There are strict guidelines for ensuring access to health care 24 hours a day, 7 days a week:

- Providers must be available 24 hours a day by telephone.
- An on-call provider must be available to take calls when the member’s provider is not available.

**After-Hours Services**

All PCPs must have an after-hours system in place to ensure that our members can call with medical concerns or questions after normal office hours. The answering service or after-hours personnel must forward member calls directly to the PCP or on-call physician, or instruct the member that the provider will be in contact within 30 minutes. UniCare will monitor PCP compliance with after-hours access
standards on a regular basis. Failure to comply may result in corrective action. For additional information, refer to the After-Hours Services section of this manual.

**Emergencies**
The answering service or after-hours personnel must ask the member if the call is an emergency. In the event of an emergency, the member must be directed to dial 911 immediately or proceed to the nearest hospital emergency room.

If the PCP’s staff or answering service is not available, an answering machine may be used. The answering machine message must instruct members who have emergency health care needs to dial 911 or go directly to the nearest hospital emergency room. The message must give members an alternative contact number to reach the PCP or on-call provider with medical concerns or questions.

**Language-Appropriate Messages**
Non-English speaking members who call their PCP after hours should expect to get language-appropriate messages. In the event of an emergency, these messages should direct the member to dial 911 or proceed directly to the nearest hospital emergency room. In a nonemergency situation, members should receive instructions about how to contact the on-call provider. If an answering service is used, the service should know where to contact a telephone interpreter for the member. All calls taken by an answering service must be returned.

**Network On-Call Providers**
UniCare prefers that PCPs use network providers for on-call services. When that is not possible, the PCP must ensure that the covering on-call physician or other provider abides by the terms of the UniCare provider contract.

**24/7 NurseLine** Members may call the 24/7 NurseLine 24 hours a day, 7 days a week at 1-888-850-1108 to speak to a registered nurse. 24/7 NurseLine nurses provide health information regarding illness and options for accessing care, including emergency services.

**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.

**Eligibility Verification**
All providers must verify member eligibility immediately before rendering services, supplies or equipment. Because eligibility may change monthly, a member eligible on the last day of the month may not be eligible on the first of the following month. UniCare is not responsible for charges incurred by ineligible persons. For details, refer to the How to Verify Member Eligibility section of this manual.

**Collaboration**
Providers share the responsibility of giving respectful care, working collaboratively with UniCare specialists, hospitals, ancillary providers and members and their families. Providers must permit members to participate actively in decisions regarding medical care, including, except as limited by law, their decision to refuse treatment. The provider facilitates interpreter services and provides information about the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program.
Continuity of Care
PCPs maintain frequent communication with specialists, hospitals and ancillary providers to ensure continuity of care. UniCare encourages providers to maintain open communication with members about appropriate treatment alternatives, regardless of the member’s benefit coverage limitations. PCPs are responsible for providing an ongoing source of primary care appropriate to the member’s needs. UniCare has established comprehensive mechanisms to ensure continued access to care for members when providers leave our health care program. Under certain circumstances, members may finish a course of treatment with the terminating provider. For more information, refer to the Provider Contract Termination section of this manual.

Medical Records Standards
Medical records must be maintained in a manner ensuring effective and confidential member care and quality review. At UniCare, we perform medical record reviews upon signing a provider contract. We then perform medical record reviews at least every three years to ensure that providers remain in compliance with these standards. Quality chart reviews are periodically conducted based on HEDIS and quality information. These reviews are designed to be educational and support quality activities. Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act. This act prohibits a health care provider from disclosing any individually identifiable information regarding a patient’s medical history, treatment, or behavioral and physical condition, without the patient’s or legal representative’s consent or specific legal authority. Records required through a legal instrument may be released without patient or patient representative consent. Providers must be familiar with the HIPAA security requirements and be in compliance.

Additional information on medical record storage, standards and security may be found in Chapter 20, beginning with the Medical Record Documentation Standards section.

Mandatory Reporting of Child Abuse, Elder Abuse or Domestic Violence
Providers must ensure that office staff is familiar with local reporting requirements and procedures regarding telephonic and written reporting of known or suspected cases of abuse. All health care providers must report immediately any actual or suspected child abuse, elder abuse or domestic violence to the local law enforcement agency by telephone. In addition, providers must submit a follow-up written report to the local law enforcement agency within the time frames required by law.

Updating Provider Information
Providers are required to inform UniCare of any material changes to their practice, including changes in:

- Professional business ownership
- Business address or the location where services are provided
- Nine-digit federal Tax Identification Number (TIN)
- Specialty
- Demographic data
- Services offered to children
- Languages spoken
- Legal or governmental action initiated against a health care provider. This type of action includes, but is not limited to, an action for professional negligence, for violation of the law, or against any license or accreditation. If successful, this action would impair the ability of the health care provider to carry out the duties and obligations under the Provider Agreement.
• Any other problems or situations that may impair the ability of the health care provider to carry out the duties and obligations under the Provider Agreement care review and grievance resolution procedures
• Notification that the provider is accepting new patients

Use the Provider Maintenance Form to notify UniCare of changes.

Oversight of NonPhysician Practitioners
All providers using nonphysician practitioners must provide supervision and oversight of these practitioners consistent with state and federal laws. The supervising physician and the non-physician practitioner must have written guidelines for adequate supervision. All supervising providers must follow state licensing and certification requirements.

Open Clinical Dialogue and Affirmative Statement
Nothing within the Provider Agreement or this manual should be construed as encouraging providers to restrict medically necessary, covered services or to limit clinical dialog between providers and their patients. Providers may communicate freely with members regarding the available treatment options, including medications, regardless of benefit coverage limitations.

We will not prohibit or otherwise restrict practitioners acting within the lawful scope of practice from advising or advocating on behalf of their patients about their health status, medical care or treatment options.

Provider Contract Termination
A terminated provider who is actively treating members must continue treatment until the termination date. The termination date is the end of the 90-day period following written notice of termination, or according to a timeline determined by the contract.

After we receive a provider’s notice to terminate a contract, we notify members impacted by the termination. UniCare sends a letter to inform affected members about:
• The impending termination of the provider
• The member’s right to request continued access to care
• The Customer Care Center phone number to request PCP changes
• Referrals to the UM department for continued access to care consideration

Members under the care of specialists may submit requests for continued access to care, including after the transition period, by calling the Customer Care Center at 1-800-782-0095.

UniCare may terminate the Provider Agreement if we determine that the quality of care or services given by a health care provider is not satisfactory. We make this determination by reviewing member satisfaction surveys, utilization management data, member complaints or grievances, other complaints or lawsuits alleging professional negligence and quality of care indicators.

Termination of the Ancillary Provider/Patient Relationship
Under certain circumstances, an ancillary provider may terminate the professional relationship with a member, as provided for and in accordance with the provisions of this manual. However, ancillary
providers may not terminate the relationship because of the member’s medical condition or the amount, type or cost of covered services required by the member.

**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 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.

**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
Overview
At UniCare, we believe that providing quality health care should not be limited to the treatment of injury or illness. We are committed to helping providers and members become more proactive in the quest for better overall health. To accomplish this goal, we offer tools for providers to find the best, most cost-effective ways to:

- Provide member treatment
- Empower members through education
- Encourage member lifestyle changes, when possible

We want providers to have access to the most up-to-date clinical practice and preventive health care guidelines that are offered by nationally recognized health care organizations and based on extensive research. These guidelines include the latest standards for treating the most common and serious illnesses, such as diabetes and hypertension. These guidelines also include recommendations for preventive screenings, immunizations and member counseling based on age and gender.

Preventive Health Care Guidelines
UniCare considers preventive health guidelines to be an important component of health care. UniCare develops preventive health guidelines in accordance with recommendations made by nationally-recognized organizations such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetrics and Gynecology (ACOG) and the United States Preventive Services Task Force (USPSTF). These organizations make recommendations based on reasonable medical evidence.

We review the guidelines annually for content accuracy, current primary sources, new technological advances and recent medical research. We make appropriate changes based on this review of the recommendations and/or preventive health mandates. We encourage providers to utilize these guidelines to improve the health of our members.

Locate the guidelines, educational materials and health management programs on our website at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website. The preventive health care guidelines available include the following:

- Medical Policy Preventive Health Guidelines
- United States Health and Human Services Administration for Children and Families Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- In the Member Preventive Health Care Guidelines section: Preventive Health Care Guidelines

The UniCare website offers the most up-to-date clinical resources for preventive screenings, immunizations and counseling for our members. If you do not have Internet access, request a hard copy of the preventive health care guidelines by calling our Customer Care Center at 1-800-782-0095.

Please note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Actual member benefits and eligibility are determined in accordance with the
requirements set forth by the state and as set forth in the member’s Evidence of Coverage and Member Handbook.

**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 [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.

**Clinical Practice Guidelines**

UniCare considers clinical practice guidelines to be an important component of health care. UniCare adopts nationally-recognized clinical practice guidelines and encourages physicians to utilize these guidelines to improve the health of our members. Several national organizations produce guidelines for asthma, diabetes, hypertension and other conditions. The guidelines, which UniCare uses for quality and disease management programs, are based on reasonable medical evidence. We review the guidelines at least every two years, or when changes are made to national guidelines, for content accuracy, current primary sources, new technological advances and recent medical research.

Providers may access the up-to-date listing of the clinical practice guidelines on the provider website at [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 UniCare website offers the most up-to-date clinical resources and guidelines. If you do not have Internet access, request a hard copy of the clinical practice guidelines by calling our Customer Care Center at 1-800-782-0095.

**Please note:** Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Actual member benefits and eligibility for services are determined in accordance with the requirements set forth by the state and as set forth in the member’s Evidence of Coverage and Member Handbook.
CHAPTER 18: CASE MANAGEMENT

Case Management phone: 1-304-347-2475
Case Management email: wvcmreferrals@anthem.com
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

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 on the provider website at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

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 LCSWs and LPCs, some of whom are certified case managers. The team also includes social workers, who add valuable skills that allow us to address our members’ medical needs, as well as psychological, social and financial issues.

Provider Responsibilities
PCPs have the responsibility of participating in case management, sharing information and facilitating the process by:
- Referring members who could benefit from case management.
- Sharing information as soon as the PCP identifies complex health care needs.
- Collaborating with Case Management staff on an ongoing basis.
- Referring members to specialists, as required.
- Monitoring and updating the care plan to promote health care goals.
• Notifying Case Management if members are referred to services provided by the state or some other institution not covered by the UniCare agreement.
• Coordinating county- or state-linked services such as public health, behavioral health, schools and waiver programs. The provider may call Case Management for additional assistance.

Case Management Procedure
When a member has been identified as having a condition that may require case management, the case manager contacts the member and the referring provider (if the referral was from a provider) for an initial assessment. Then, with the involvement of the member, the member’s representative and the provider, the case manager develops an individualized care plan. This plan may involve coordinating services with public and behavioral health departments, schools, and other community health resources.

The case manager periodically re-assesses the care plan to monitor the following:
• Progress toward goals
• Necessary revisions
• New issues to be addressed to ensure the member receives the support necessary to achieve care plan goals

After goals are met or case management can no longer impact the case, the case manager closes the case.

Potential Referrals
Providers, nurses, social workers and members or their representatives may request Case Management services. Examples of cases appropriate for referral include:
• Children or adults with special health care needs requiring coordination of care
• HIV/AIDS
• Chronic illness such as asthma, diabetes and heart failure
• Complex- or multiple-care needs such as multiple trauma or cancer
• Frequent hospitalizations or emergency room utilization
• Hemophilia, sickle cell anemia, cystic fibrosis or cerebral palsy
• High-risk or teen pregnancies
• Potential transplants
• Preterm births

Referral Process
To request case management services, providers, nurses, social workers, and members or their representatives may call 1-304-347-2475 or send a Care Management Referral Form by email to wvcmsreferrals@anthem.com. A case manager will respond to a request within three business days. Download the Care Management Referral Form on the provider website at www.unicare.com. For directions on how to access our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.
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. 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.

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.
CHAPTER 19: Disease Management/Population Health

Overview
Our Disease Management (DM) is based on a system of coordinated care management interventions and communications designed to assist physicians and other health care professionals manage members with chronic conditions. DM services include a holistic, member-centric care management approach that allows case managers to focus on multiple needs of members. Our disease management programs include:

- Asthma
- Chronic obstructive disorder (COPD)
- Congestive health failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Substance use disorder
- Bipolar disorder
- Major depressive disorder — adult and child/adolescent
- Schizophrenia

In addition to our 12, condition-specific disease management programs, our member-centric, holistic approach also allows us to assist members with smoking and weight management education.

Program Features
- Proactive population identification process
- Evidence-based clinical practice guidelines from recognized sources
- Collaborative practice models that include the physician and support providers in treatment planning
- Continuous self-management education, including primary prevention, coaching related to healthy behaviors and compliance/monitoring, and case management for high risk members
- Ongoing communication with primary and ancillary providers regarding patient status
- Nine of our Disease Management programs are National Committee for Quality Assurance accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care

Additionally, all our programs are based on nationally approved clinical practice guidelines are located at [www.unicare.com](http://www.unicare.com). A copy of the guidelines can be printed from the website.

Objectives
Disease Management programs are designed to:

- Address gaps in care.
- Improve the understanding of disease processes.
- Improve the quality of life for our members.
- Collaborate to develop member-centered goals and interventions.
- Support relationships between member and network providers.
- Increase network provider awareness of Disease Management programs.
- Reduce acute episodes requiring emergent or inpatient care.
- Identify barriers to health care and address by referring members to appropriate community resources

Who is Eligible?
All members with the listed conditions are eligible. We identify them through:
- Continuous case finding
- Claims mining
- Referrals

How Can You Use DM Services?
As a valued provider, we welcome your referrals of patients who can benefit from additional education and case management support. Our case managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk stratified based on the severity of their disease. Program evaluation, outcome measurement and process improvement are built into all the programs. Providers are given telephonic and/or written updates regarding patient status and progress.

Provider Rights and Responsibilities
You have the right to:
- Have information about UniCare, including:
  - Provided program and services
  - Our staff
  - Our staff’s qualifications
  - Any contractual relationships
- Decline to participate in or work with any of our programs and services for your patients
- Be informed of how we coordinate our interventions with your patient’s treatment plans
- Know how to contact the person who manages and communicates with your patients
- Be supported by our organization when interacting with patients to make decisions about their health care
- Receive courteous and respectful treatment from our staff
- Communicate complaints about DM as outlined in the UniCare provider complaint and Grievance procedure

Hours of Operation
Our DM case managers are registered nurses. They are available:
- 8:30 a.m. to 5:30 p.m. local time
- Confidential voicemail is available 24 hours a day. The Nurse Helpline is available for our member 24 hours a day, 7 days a week.

Contact Information
You can call a DM team member at 1-888-830-4300. Additional information about DM program content is located www.unicare.com. Members can obtain information about the DM program by visiting www.unicare.com or calling 1-888-830-4300.
Overview
UniCare operates with an unyielding commitment to meeting our diverse customers’ needs. Our vision statement is “Be the most innovative, valuable and inclusive partner”.

The Plan is committed to excellence in the quality of care and services provided to members, and to the provider networks competency. The Plan is dedicated to improving member satisfaction, improving the health status and quality of care for our members and the public, providing value added services, improving member safety, and maintaining member access to medical and behavioral health services.

The Plan’s QM Program is an ongoing, comprehensive, and integrated system which defines how departments support quality objectively and systematically monitors and evaluates the quality, safety and appropriateness of medical and behavioral health care and service the health network offers and identifies and acts on opportunities for improvement. We are evolving and building upon our culture with a focus on continuous improvement. Our values provide an overall foundation for success, helping define what we do and how we do it. The Plan lives these values, drive to deliver winning results and raise the bar through continuous improvement. The Plan values are:

Leadership – Redefine what’s possible
Community – Committed, connected, invested
Integrity – Do the right thing, with a spirit of excellence
Agility – Deliver today – transform tomorrow
Diversity – Open your hearts and minds

Quality Improvement Program
The QM Program’s overall goal is to improve the quality and safety of clinical care and services provided to members through UniCare’s network of providers and its programs and services. Specific goals are established to support the QM Program purpose. All goals are reviewed annually and revised as needed.

The QM Program goals are to:

- Develop and maintain QM resources, structure and processes that support the organization’s commitment to quality health care for our members.
- Continuously improve the quality of care and service provided to members.
- Improve or maintain positive member and provider experiences through data analysis and implementing effective interventions.
- Monitor and maintain full compliance with all applicable state, federal and accreditation requirements.
- Implement and oversee a comprehensive Population Health Strategy that addresses:
  - Keeping members healthy.
  - Managing members with emerging risk.
  - Patient safety or outcomes across settings.
- Managing chronic illness.
- Monitor for and maintain patient safety and promote safe clinical practices.
• Determine if vulnerable and special needs populations have adequate access and maintain that access to appropriate care management programs, including Complex Case Management, Case Management and Disease Management and if available LTSS Programs
• Maintain compliance with the Cultural and Linguistically Appropriate Services (CLAS) standards through a Health Disparities Program
• Establish and maintain effective credentialing and re-credentialing processes for providers that comply with state, federal and accreditation requirements
• Provide appropriate access to care by monitoring practitioner and provider access and availability reports
• Provide oversight for all delegated activities to maintain compliance with all state, federal and accrediting organizations

Annually, specific activities and objectives are identified and recorded in the QM Work Plan document along with responsible staff members to monitor the progress to achieving the goals of newly and previously identified issues. Specific time frames for completion of each activity are established.

Healthcare Effectiveness Data and Information Set
HEDIS is a national evaluation and a core set of performance measurements gauging the effectiveness of UniCare and the network providers in delivering quality care. We are ready to help when the providers and their office staff need training to participate in required HEDIS evaluations. Providers can request consultations and training in the following areas:
- Information about the year’s selected HEDIS studies
- How data for those measures will be collected
- Codes associated with each measure
- Tips for smooth coordination of medical record data collection

UniCare’s QI staff will contact the provider’s office when we need to review or copy any medical records required for HEDIS or QI studies. UniCare requests that records be returned within five business days to allow time to abstract the records and request additional information from other providers, if needed. Office staff must provide access to medical records for review and copy, if necessary.

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 Management
Annually, and in accordance with NCQA standards, UniCare analyzes relevant utilization data against established thresholds for each health plan to detect current utilization levels. If our findings fall outside specified target ranges and indicate potential under-utilization or over-utilization, further analysis will occur based on the recommendation of UniCare’s Quality Management Committee (QMC). The follow-up analysis may include gathering the following data from specific provider and practice sites:

- Case management services needed by members
- Claims payments for covered services
- Coordination with other providers and agencies
- Focus studies
- Investigation and resolution of member and provider complaints and appeals within established time frames
- Retrospective reviews of services provided without authorization

Best Practice Methods
Best practice methods are UniCare’s most up-to-date compilation of effective strategies for quality health care delivery. We share best practice methods during site visits to provider offices. The Network Management teams offer UniCare policies, procedures and educational toolkits to help guide improvements. Toolkits may include examples of best practices from other offices, including:

- Resources for improving compliance with preventive health services
- Clinical practice guidelines
- Care for members with special or chronic care needs

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.

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.

Facility Site and Medical Record Reviews
UniCare conducts facility site and medical record reviews to determine provider:

- Compliance with standards for providing and documenting health care.
- Compliance with standards for storing medical records.
- Compliance with processes that maintain safety standards and practices.
- Involvement in the continuity and coordination of member care.
Please note: BMS and UniCare have the right to enter into the premises of providers to inspect, monitor, audit or otherwise evaluate the work performed. We perform all inspections and evaluations in such a manner as to not unduly delay work, in accordance with the provider contract.

Medical Record Documentation Standards
UniCare requires providers to maintain medical records in a manner that is current, organized, and permits effective and confidential member care and quality review. We perform medical record reviews of all providers upon signing of a contract and, at a minimum, every three years thereafter to ensure that network providers are in compliance with these standards.

Providers must agree to maintain the confidentiality of member information and other information contained in a member’s medical record according to HIPAA standards. The Confidentiality of Medical Information Act prohibits a provider of health care from disclosing any individually-identifiable information regarding a patient’s medical history, mental and physical condition, or treatment without the patient’s or legal representative’s consent or specific legal authority. The provider will release such information only as permitted by applicable federal, state and local laws. Any information released must be necessary to other providers and the health plan, related to treatment, payment, or health care operations. In addition, information must be released upon the member’s signed and written consent.

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.

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.

Availability of Medical Records
The medical record system must allow for prompt retrieval of each record when the member comes in for a visit. Providers must maintain members’ medical records in a detailed and comprehensive manner that accomplishes the following:

- Conforms to good professional medical practice
- Facilitates an accurate system for follow-up treatment
- Permits effective, professional medical review and medical audit processes

Medical records must be legible, signed and dated, and maintained for at least seven years as required by state and federal regulations.
Providers must supply a copy of a member’s medical record upon reasonable request by the member at no charge. The provider must facilitate the transfer of the member’s medical record to another provider at the member’s request. Access to medical records and confidentiality must be provided in accordance with the standards mandated in HIPAA, as well as all other state and federal requirements.

Providers must permit UniCare and representatives of BMS to review members’ medical records for the purposes of monitoring the provider’s compliance with the medical record standards, capturing information for clinical studies, monitoring quality, or any other reason. BMS encourages providers to use technology, such as health information exchanges, to transmit and store medical record data.

**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
- Up-to-date immunization records for children, or an appropriate history for adults
- Documentation of attempts to provide immunizations. If the member refuses immunization, document proof of voluntary refusal of the immunization in the form of a signed statement by the member or guardian
- Evidence of preventive screening and services in accordance with UniCare’s preventive health practice guidelines
- Documentation of referrals, consultations, diagnostic test results, and inpatient records. Evidence of the provider’s review may include the provider’s initials or signature and notation in the patient’s medical record. The provider may indicate review and patient contact, follow-up treatment, instructions, return office visits, referrals and other patient information
• Notations of appointment cancellations or No Shows and the attempts to contact the member to reschedule
• No indication or implication that the patient was placed at inappropriate risk by a diagnostic test or therapeutic procedure
• Documentation on whether an interpreter was used in any visit (initial or follow-up)

**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 redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please contact the Customer Care Center at 1-800-782-0095.

**Advance Directives**
Recognizing a person’s right to dignity and privacy, our members have the right to execute an advance directive, also known as a living will, to identify their wishes concerning health care services should they become incapacitated. Providers may be asked to assist members in procuring and completing the necessary forms. For more information, go to [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.

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.

**Medical Record Review Process**
UniCare’s QI team will call the provider’s office to schedule a medical record review on a date and time that will occur within 30 days. On the day of the review, the QI staff will:
1. Request the number and type of medical records required.
2. Review the appropriate number and type of medical records per provider.
3. Complete the medical record review.
4. Meet with the provider or office manager to review and discuss the results of the medical record review.
5. Provide a copy of the medical record review results to the office manager or provider, or send a final copy within 10 days of the review.
6. Schedule follow-up reviews for any corrective actions identified.

Providers must attain a score of 80% or greater to pass the medical record review.

**Facility Site Review Process**
An initial facility site review and inspection is required for all PCP sites, OB/GYNs and high-volume specialists participating in the UniCare program.
A facility site review inspection consists of 13 elements, including the following:
1. Accessibility
2. Appearance
3. Safety and infectious waste disposal
4. Office policies
5. Provider availability
6. Treatment areas
7. Patient services
8. Process of documentation  
9. Personnel  
10. Medications, including emergency supplies  
11. Referral process  
12. Medical records elements and organization  
13. Appointment accessibility  

A facility site review is required if the site has not been previously reviewed and accepted as part of UniCare’s credentialing process. In addition:

- Facility site reviews are required as part of the initial credentialing process for new providers, as well as every three years. In addition, if a provider reaches a threshold of three complaints in a rolling twelve months, a facility site review will be conducted.  
- OB/GYN specialty sites and high-volume specialists participating in the UniCare program and not serving as PCPs must undergo an initial site inspection.  
- Practitioners must notify UniCare when relocating to a new site or when adding a new site. If a review has not been previously performed at the new site, UniCare will perform a facility site review prior to members being seen.  

A UniCare QI department associate will call the provider’s office to schedule an appointment date and time before the facility site review due date. The associate will fax or mail a confirmation letter with an explanation of the audit process and required documentation. During the facility site review, the QI associate will:

1. Lead a pre-review conference with the provider or office manager to review and discuss the facility review process and answer any questions.  
2. Conduct the facility site review.  
3. Complete the facility site review.  
4. Develop a corrective action plan, if applicable.  

After the facility site review is completed, UniCare’s QI associate will meet with the provider or office manager to:

1. Review and discuss the results of the facility site review and explain any required corrective actions.  
2. Provide a copy of the facility site review results and the corrective action plan to the office manager or provider. Or, the QI associate may send a final copy within 10 days of the review.  
3. Educate the provider and office staff about UniCare standards and policies.  
4. Schedule a follow-up review for any corrective actions identified.  

Providers must attain a score of 80% or greater with no deficiencies in critical elements to pass the facility site review.

**Critical Elements:** Critical elements include making sure sharps containers are present, autoclave spore testing*, universal precautions, medication storage, and availability of emergency equipment*. Full compliance with critical elements must be attained.

*When applicable.

**Facility Site Review: Corrective Actions**

If the facility site review results in a nonpassing score, UniCare will notify providers immediately of the nonpassing score, all cited deficiencies and corrective action requirements. The provider office will develop and submit a corrective action plan. UniCare will conduct follow-up visits every six months until the site complies with UniCare standards.
The provider and office staff will:

- Submit a corrective action plan with verification for all critical elements and/or other survey deficiencies requiring immediate correction within 10 business days of the survey. Critical element deficiencies will be re-evaluated within 30 days of the site visit. Additional time may be granted, if necessary.
- Submit a corrective action plan for all other deficiencies within 30 days of the survey.

If deficiencies (other than critical) are not closed within 60 days of the date of the written corrective action plan request, or if the provider is otherwise uncooperative with resolving outstanding issues with the facility site review, the provider will be considered noncompliant.

**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.
Practitioner / Provider Performance Data

Practitioner/provider performance data means compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual health care practitioner, such as a physician, or a health care organization, such as a hospital.

Common examples of performance data would include the HEDIS quality of care measures maintained by the National Committee for Quality Assurance (NCQA) and the comprehensive set of measures maintained by the National Quality Forum (NQF).

Practitioner/provider performance data may be used for multiple plan programs and initiatives, including but not limited to:

- Reward programs — pay for performance (P4P), pay for value (PFV) and other results-based reimbursement programs that tie provider or facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules and bundled payment arrangements.
- Recognition programs — programs designed to transparently identify high-value providers and facilities and make that information available to consumers, employers, peer practitioners and other health care stakeholders.
CHAPTER 21: ENROLLMENT AND MARKETING RULES

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

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.

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, gender, gender identity, sexual orientation, physical or mental disability, health status or existing need for medical care, with the following exception: certain gifts and services may be made available to members with certain diagnoses

Assisting with Medicaid MCO enrollment form

Making false, misleading or inaccurate statements relating to services or benefits of the MCO or Medicaid program, or relating to the providers or potential providers contracting with the MCO

Using social media as a means to:
  o Post or send protected private information
  o Advertise via direct communication with potential members
  o Directly respond to any members for anything other than a general response (such as MCO phone number or website links)
  o Partake in individual communication
  o Request or add followers or friends
  o Tag individuals

Enrollment Process
BMS determines the eligibility and enrollment for UniCare members. The enrollment process is as follows:

- The enrollment broker presents managed health care plan options to individuals and families eligible for UniCare.
- Eligible members enroll in the plan of their choice and select a PCP; or, UniCare assigns a PCP to the member. The head-of-household completes applications and makes selections on behalf of children eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.
- The enrollment broker informs UniCare of new member enrollment. After enrollment, the broker updates UniCare about any changes in member eligibility, status or contact information, such as change of address.
- UniCare notifies providers about newly-assigned members through monthly enrollment rosters. Providers also have access to these rosters by logging into our secure provider website at [www.unicare.com](http://www.unicare.com).
- UniCare sends each new member a New Member Kit within one week of receiving the BMS monthly enrollment roster. This kit includes a Member Handbook, a letter and the Evidence of Coverage.
- UniCare sends the member ID card within five days of receiving the monthly enrollment roster. The ID card includes the PCP contact information.

Please note: BMS will re-enroll any member automatically who loses UniCare eligibility but becomes eligible again within one year or less. Members will return to the same health care plan and PCP they had prior to disenrollment, if available. Members also may choose to switch plans at the time of re-enrollment.

Please note: To support the member enrollment process, PCPs are encouraged to maintain open panels. The state requires that 80% of UniCare PCPs have open panels; your open panel will assist us in meeting this requirement.

Open panels: The commitment by UniCare-contracted providers to accept new UniCare members.
**Enrolling Newborns**

Initially, a newborn is covered under the mother’s plan. Newborn delivery notification is required using the *Newborn Enrollment Notification Report*. Complete the entire form and include the newborn’s name, date of birth and other pertinent information. Fax the completed form to 1-855-402-6983.

To prevent delay in UniCare coverage for newborns, submit the *Newborn Enrollment Notification Report* to notify UniCare about delivery within three days of the delivery.

Request that your patients take these steps as soon as their babies are born:
- Immediately contact BMS or their social worker to request the required paperwork
- Fill out and return the required paperwork to the state to enroll their newborn in Medicaid

The *Newborn Enrollment Notification Report* is located at www.unicare.com. For directions on how to access our website, please see *Chapter 1: How to Access Information, Forms and Tools on Our Website*.

**Please note:** To admit a baby for health reasons beyond a normal nursery admission, complete the *Request for Preservice Review* form in addition to the *Newborn Enrollment Notification Report*. The *Request for Preservice Review* form is located at www.unicare.com.

For directions on how to access our website, please see *Chapter 1: How to Access Information, Forms and Tools on Our Website*. 
CHAPTER 22: FRAUD, WASTE AND ABUSE

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

We are committed to protecting the integrity of our health care program and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

- **Fraud**: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person. The attempt itself is fraud regardless of whether or not it is successful.
- **Waste**: Includes overusing services or other practices which, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions but rather occurs when resources are misused.
- **Abuse**: When health care providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes or services that are not medically necessary.

To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Our company may not accept responsibility for the costs incurred by providers supplying services to a person who is not a member even if that person presents a current member identification card. Providers should take measures to ensure the cardholder is the person named on the card.

Every member identification card lists the following:
- Effective date of membership
- Member date of birth
- Subscriber number (identification number)
- Carrier and group number (RXGRP number) for an injectable
- PCP name, telephone number and address
- Copays for office visits, emergency room visits and pharmacy services (if applicable)
- Behavioral health benefit
- Vision service plan telephone number and dental service plan telephone number
- Member Services and NurseLine telephone numbers

For samples of the member ID card, refer to the “Member Identification Cards” section. Presentation of a member identification card does not guarantee eligibility; providers should verify a member’s status by inquiring online or via telephone. Online support is available for provider inquiries on the website and telephonic verification may be obtained through the automated Customer Care Center at 1-800-782-0095.

Providers should encourage members to protect their identification cards as they would a credit card, to carry their health benefits card at all times, and report any lost or stolen cards to our company as soon as possible. Understanding the various opportunities for fraud and working with members to protect their health benefit ID card can help prevent fraudulent activities. If you or a patient suspect ID theft,
call our Customer Care Center at 1-800-782-0095. Providers should instruct their patients who suspect identification theft to watch the EOB for any errors and then contact member services if something is incorrect.

**Reporting Fraud, Waste and Abuse**

If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting our website and completing the Report Waste, Fraud and Abuse form at [www.fighthealthcarefraud.com](http://www.fighthealthcarefraud.com) and then select Report It.
- Calling Provider Services.
- Calling our Special Investigations Unit fraud hotline at 1-855-315-8927.

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

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

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling — multiple procedure codes billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding — a provider billing a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened
Examples of Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the member’s identification card
- Obtaining controlled substances from multiple providers
- Relocating to out-of-service plan area
- Using someone else’s identification card

When reporting concerns involving a member include:

- The member’s name
- The member’s date of birth, Social Security Number or case number if you have it
- The city where the member resides
- Specific details describing the fraud, waste or abuse

Investigation Process

We investigate all reports of fraud, abuse and waste for all services provided under the contract, including those that subcontracted to outside entities. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste or abuse, which may include but is not limited to:

- **Written warning and/or education:** We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries, or may advise of further action.
- **Medical record audit:** We review medical records to substantiate allegations or validate claims submissions.
- **Special claims review:** A certified professional coder or investigator evaluates claims and places payment or system edits on file. This type of review prevents automatic claim payment in specific situations.
- **Recoveries:** We recover overpayments directly from the provider within 30 days. Failure of the provider to return the overpayment after 30 days may result in reduced payment of future claims or further legal action.

Acting on Investigative Findings

We refer all criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

If a provider appears to have committed fraud, waste, or abuse the provider:

- Will be referred to the Special Investigations Unit
- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our health care plan with state approval.
Relevant Legislation

False Claims Act
We are committed to complying with all applicable federal and state laws, including the Federal False Claims Act (FCA). The FCA is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim.

The FCA also contains qui tam or whistleblower provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under qui tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud and simplifies the administration of health insurance.

- Our company recognizes its responsibility under HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us; however, privacy regulations allow the transfer or sharing of member information. Our company may request information to conduct business and make decisions about care such as a member’s medical record, authorization determinations or payment appeal resolutions. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.

- Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at our company and verify the fax was received.

- Email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing member information (e.g., Excel spreadsheets with claim information; such information should be mailed or faxed.)

- Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked “confidential” and addressed to a specific individual, P.O. Box or department at our company.

- Our company voicemail system is secure and password-protected. When leaving messages for any of our associates, leave only the minimum amount of member information required to accomplish the intended purpose.

- When contacting us, please be prepared to verify the provider’s name, address and tax identification number (TIN) or member’s provider number.

- All laws regarding the privacy, security and confidentiality of health care information and a patient’s rights to his or her medical information and personal information shall apply to Telehealth interactions. This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. Telehealth services are used to support health care when the provider and patient are physically separated. Typically, the patient communicates with the provider via interactive means i.e. live audio/video feed. Participating Providers and Facilities shall be solely responsible for ensuring the security and privacy of their interactive audio/video
platform. Such platform must at a minimum include technical, administrative and physical safeguards to ensure that all information pertaining to covered members is protected in accordance with applicable law utilizing controls equivalent to those necessary for compliance with the Health Insurance Portability and Accountability Act ("HIPAA").

**Employee Education about the False Claims Act**
As a requirement of the Deficit Reduction Act of 2005, contracted providers who receive Medicaid payments of at least $5 million (cumulative from all sources), must comply with the following:

- Establish written policies for all employees, managers, officers, contractors, subcontractors and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in section 1902(a)(68)(A).

- Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, waste and abuse. Include in any employee handbook a specific discussion of the laws described in Section 1902(a) (68) (A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, waste and abuse.
CHAPTER 23: MEMBER RIGHTS AND RESPONSIBILITIES

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

Overview

Members should be clearly informed about their rights and responsibilities so they can make the best health care decisions. Members also have the right to ask questions about the way we conduct business, as well as the responsibility to learn about their health care coverage.

The member rights and responsibilities in this chapter are defined by the state of West Virginia and appear in the UniCare member welcome packets. You may view the Member Rights and Responsibilities in the Forms and Tools section of the Provider Resources page at www.unicare.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Members have certain rights and responsibilities when receiving their health care. They have a responsibility to take an active role in their care. We are committed to making sure members’ rights are respected while providing their health benefits. This also means providing access to UniCare network providers and the information members need to make the best decisions for their health and welfare.

Member Rights

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, gender, gender identity, sexual orientation, race, national origin, language needs or degree of illness or health condition.
- Talk to their doctor about things that are private.
- Have problems taken care of fast, including things they think are wrong, as well as issues about getting an OK from us, their coverage or payment of service.
- Be treated the same as others.
- Get care that should be done for medical reasons.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Choose their PCP from the PCPs in our provider directory that are taking new patients.
• Use providers who are in our network.
• Get medical care in a timely manner.
• Get services from providers outside our network in an emergency.
• Refuse care from their PCP or other caregivers.
• Be able to make choices about their health care.
• Make an advance directive (also called a living will).
• Tell us their concerns about UniCare and the health care services they get.
• Question a decision we make about coverage for care they got from their doctor.
• File a complaint or an appeal about UniCare, any care they get or if their language needs are not met.
• Ask how many grievances and appeals have been filed and why.
• Tell us what they think about their rights and responsibilities and suggest changes.
• Ask us about our Quality Improvement (QI) program and tell us how they would like to see changes made.
• Ask us about our utilization review process and give us ideas on how to change it.
• Know that the date they joined our health plan is used to decide their benefits.
• Know that we only cover health care services that are part of their plan.
• Know that we can make changes to their health plan benefits as long as we tell them about those changes in writing.
• Ask for their Evidence of Coverage and Member Handbook and other member materials in other formats such as large print, audio CD or Braille at no charge to them.
• Ask for an oral Interpreter and translation services at no cost to them.
• Use interpreters who are not their family members or friends.
• Know they will not be held liable if their health plan becomes bankrupt (insolvent).
• Ask us about our Quality Improvement (QI) program and tell us how they would like to see changes made.

**Member Responsibilities**

Members have the responsibility to:

• Tell us, their doctors and other health care providers what they need to know to treat them.
• Learn as much as they can about their health issue and work with their provider to set up treatment goals they agree on.
• Ask questions about any medical issue and make sure they understand what their provider tells them.
• Follow the care plan and instructions, to the best of their ability, that they have agreed on with their provider or other health care professionals.
• Do the things that keep them from getting sick.
• Make and keep medical appointments and tell their provider at least 24 hours in advance when they cannot make it.
• Always show their member identification (ID) card when they get health care services.
• Use the emergency room only in cases of an emergency or as their provider tells them.
• Tell us right away if they get a bill that they should not have gotten or if they have a complaint.
• Treat all UniCare staff and doctors with respect and courtesy.
• Know and follow the rules of their health plan.
• Know that laws guide their health plan and the services they get.
• Know that we do not take the place of workers’ compensation insurance.
• Tell us and their Department of Health and Human Resources (DHHR) case worker when they change their address, family status or other health care coverage.
CHAPTER 24: CULTURAL DIVERSITY AND LINGUISTIC SERVICES

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

Overview

At UniCare, we recognize that providing health care services to a diverse population may present challenges. We know it is important to continually increase your knowledge of, and ability to support, the values, beliefs, and needs of diverse patients. Differences in our members’ ability to read may add an extra dimension of difficulty when providers try to encourage follow-through on treatment plans. UniCare’s cultural diversity and linguistic services toolkit, called Caring for Diverse Populations, was developed to give you specific tools for breaking through cultural and language barriers in an effort to better communicate with your patients.

Sometimes the solution is as simple as finding the right interpreter for an office visit. Other times, a greater level of cultural awareness opens the door to the kind of interaction that makes treatment plans most effective: Has the patient been raised in a culture that frowns upon direct eye contact or receiving medical treatment from a member of the opposite sex? Is the patient self-conscious about his or her ability to read instructions?

The cultural diversity and linguistic services toolkit provides information you need to answer those questions and continue building trust. The toolkit enhances your ability to communicate with ease to a wide range of people about a variety of culturally-sensitive topics. Finally, the toolkit offers cultural and linguistic training to your office staff, enabling all aspects of an office visit to go smoothly.

We strongly encourage you to access the complete toolkit our website at www.unicare.com. For directions on how to access our provider website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

The toolkit contents are organized into the following sections:

- Resources to assist communication with a diverse patient population base
- Resources to communicate across language barriers
- Resources to increase awareness of cultural background and its impact on health care delivery
- Regulations and standards for cultural and linguistic services
- Resources for cultural and linguistic services

Resources to Assist Communication with a Diverse Patient Population Base

- Tips for providers and clinical staff
- A mnemonic to assist with patient interviews
- Help in identifying literacy problems
- An interview guide for hiring clinical staff who have an awareness of cultural competency issues

Resources to Communicate Across Language Barriers

- Tips for locating and working with interpreters
- 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

This section identifies important legislation impacting cultural and linguistic services, including a summary of the Culturally and Linguistically Appropriate Services (CLAS) standards, which serve as a guide on how to meet these requirements.

Resources for Cultural and Linguistic Services

- A bibliography of print and Internet resources for conducting an assessment of the cultural and linguistic needs of your own practice’s patient population
- Staff and physician cultural and linguistic competency training resources
- Links to additional tools in multiple languages and/or written for limited English proficiency

The toolkit contains materials developed by and used with the permission of the Industry Collaboration Effort (ICE*). ICE is a volunteer, multi-disciplinary team of providers, health plans, associations, state and federal agencies and accrediting bodies working collaboratively to improve health care regulatory compliance through education of the public. Locate more information about ICE on its website at www.iceforhealth.org.

In addition to the Caring for Diverse Populations toolkit, UniCare offers additional resources to support provision of culturally and linguistically appropriate services, including My Diverse Patients and a Cultural Competency Training, which can also be accessed at www.unicare.com. For directions on how to access our provider website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website. My Diverse Patients is a resource-rich care provider website that covers topics relevant to providing culturally competent care and services for diverse individuals. The Cultural Competency Training offers information on key components to the provision of culturally competent care.

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.

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 Prescreening Tool, found in the Caring for Diverse Populations toolkit, to help begin assessing the level of proficiency with non-English languages. Please provide updates on the language capabilities of your office staff annually and at least every three years for yourself. In addition to meeting the linguistic needs of our members, UniCare strives to meet the ethnic and cultural preference of our members. An important component of this is capturing ethnicity data during the credentialing process. Language capability and provider ethnicity information will be reported in the provider directory to help members find a provider and/or office that can communicate in their preferred language and meets their cultural preferences.

Provide these updates using the Provider Maintenance Form.
Interpreter Services
For those instances when you cannot communicate with a member due to language barriers, interpreter services are available at no cost to you or the member. UniCare provides over-the-phone and face-to-face interpreters. Providers must notify members of the availability of interpreter services and strongly discourage the use of friends and family, particularly minors, to act as interpreters. You or your office staff should document the member’s preferred language other than English in the member’s medical record, any refusal of interpreter services, and requests to use a family member or friend as an interpreter.

Face-to-face interpreters for members needing language assistance, including American Sign Language, are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required. Over-the-phone interpreters are available 24 hours a day, 7 days a week.

To request interpreter services, providers and members should call UniCare’s Customer Care Center at 1-800-782-0095. For after-hours nurse services, call the 24/7 NurseLine at 1-888-850-1108. Take the following steps to initiate interpreter services when a member is on the phone line with you:

1. Give the member’s identification (ID) number to the Customer Care or 24/7 NurseLine associate.
2. Explain the need for an interpreter and state the language required.
3. Wait on the line while the connection is made.
4. Once connected to the interpreter, the Customer Care or 24/7 NurseLine associate introduces the UniCare member, explains the reason for the call, and begins the dialogue.

For members with hearing or speech loss, West Virginia Relay Service is a toll-free TDD service. Call 711 or the following numbers:
- For voice to TDD: 1-866-368-1634
- For TDD to voice: 1-800-982-8771

For additional information on interpreter services, access the Health Education section of the Provider Resources page at www.unicare.com. For directions on how to access the provider website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Americans with Disabilities Act
Providers must comply with all applicable federal and state laws in assuring accessibility to all services for members with disabilities, pursuant to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973, maintaining the capacity to deliver services in a manner that accommodates the needs of its members. Providers contracted with UniCare are required by law to provide disabled persons full and equal access to medical services.

Although a review of the requirements of the law and implementing regulations can be daunting, providing full and equal access to persons with disabilities can be achieved by:
- Removing physical barriers.
- Providing means for effective communication with people who have vision, hearing or speech disabilities, including providing auxiliary aids as needed.
- Providing flexibility in scheduling to accommodate people with disabilities.
- Allowing extra time for members with disabilities to dress and undress, transfer to examination tables, and extra time with the provider in order to ensure the individual is fully participating and understands the information.
• Making reasonable modifications to policies, practices and procedures.

For more information on making changes to a practice to ensure ADA compliance, providers can refer to these additional resources:
• https://www.ada.gov
• https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm

* Availity, LLC is an independent company providing administrative support services on behalf of UniCare Health Plan of West Virginia, Inc. Skygen Dental is an independent company providing dental benefit management services on behalf of UniCare Health Plan of West Virginia, Inc. AIM Specialty Health is an independent company providing some utilization review services on behalf of UniCare Health Plan of West Virginia, Inc. Industry Collaboration Efforts is an independent company providing member education services on behalf of UniCare Health Plan of West Virginia, Inc. Molinia Healthcare is an independent company providing pharmacy helpdesk services on behalf of UniCare Health Plan of West Virginia, Inc. Weigh Watchers is an independent company providing diet monitoring services on behalf of UniCare Health Plan of West Virginia, Inc