



**Physician, Health Care
Professional, Facility and Ancillary
Administrative Guide**



Unison Health Plan of Delaware 2010



Unison Health Plan of Delaware Directory of Departments

Unison Health Plan Website <i>Check up-to-date claim and eligibility information available, 24/7.</i>	www.unisonhealthplan.com
Administrative Office Delaware Office	412.858.4000 302.429.7800
Provider Services <i>Representatives are available Monday through Friday, 8 a.m. to 5 p.m. (EST).</i>	800.600.9007 866.915.0309 (Fax)
Interactive Voice Response Line <i>Use our toll-free Interactive Voice Response (IVR) system 24/7 to verify member eligibility.</i>	888.586.4766
Utilization Management (UM) <i>Staff is available Monday through Friday, 8 a.m. to 5 p.m. (EST), to assist with routine prior authorizations, admissions, discharges and coordination of members' care. On-call staff is available 24/7 for emergency prior authorization purposes.</i>	800.366.7304 877.877.8230 (fax) 877.877.8391 (DME fax)
Member Services <i>Representatives are available Monday through Friday, 8 a.m. to 5 p.m. (EST).</i>	877.877.8159 711 (hard-of-hearing)
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) <i>For Unison Medicaid members under 21 years of age.</i>	800.377.2142
Emergency Care <i>Authorization is not required if a member is treated for a medical emergency as defined in the provider contract. Unison must be contacted within 48 hours of treatment.</i>	800.366.7304
Non-Emergency Transportation <i>Non-emergency transportation is covered through Delaware Department of Health and Social Services authorization in non-emergencies, except facility-to-facility transfers.</i>	See the website for a list of participating providers.
Care Management Services <i>Representatives are available Monday through Friday, 8 a.m. to 5 p.m. (EST).</i>	800.508.2581
Healthy First Steps (Pregnancy) Program <i>Representatives are available Monday through Friday, 8 a.m. to 5 p.m. (EST).</i>	800.599.5985
Special Needs Unit (SNU) <i>To help providers and members with special medical, behavioral and social conditions access health care benefits and community resources.</i>	877.844.8844 800.473.0989 (hard-of-hearing) 877.215.9811 (Fax)
Fraud and Abuse Hotline <i>Our confidential reporting hotline is available 24/7. You may report anonymously. If you leave your telephone number, a representative will return your call.</i>	877.766.3844
Behavioral Health Care Management (Mental Health and Substance Abuse) <i>Staff is available Monday through Friday, 8 a.m. to 5 p.m. (EST), to assist with routine prior authorizations, admissions, discharges and coordination of members' care. On-call staff is available 24/7 for emergency prior authorization purposes.</i>	866.261.7692
Pharmacy and Dental Services are covered by Delaware FFS, not by Unison.	

Note: Practitioner is defined as an individual provider of clinical services. Provider is a broader term that also includes institutional or ancillary facilities, such as hospitals, laboratories and DME suppliers.



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Welcome to Unison Health Plan - 2010

Unison Health Plan of Delaware is pleased to welcome you to our team of participating providers. Unison consists of independent, public sector health plans that specialize in coordinating and financing quality, comprehensive, public sector health care. Please use this manual as a guide for providing care to Unison members. Terms and phrases used herein, which are defined in your Unison network participation agreement, bear the meaning assigned in that agreement. Terms and phrases that are not defined in the participation agreement bear the meaning specifically assigned herein (if any) or bear the commonly understood meaning.

Unison is an experienced and recognized leader in delivering quality public sector health plans. Through over ten years of experience in public sector health care, Unison has succeeded in making superior health care services available to thousands of individuals.

In Delaware, Unison offers quality health insurance to members of Delaware's Medicaid and Delaware Healthy Children Program (DHCP) clients through Unison Health Plan. Unison's Medicaid program provides payment for health care services on behalf of eligible low-income persons. In some eligibility groups, services must be under a certain dollar amount.

Unison is dedicated to working together with our valued provider team to deliver premium and accessible health care services to each of our members. Since Unison understands that you work hard to deliver quality service to our members, we are pleased to offer you the following benefits:

- Rapid and accurate claims payment system
- A Provider Services department that can quickly answer your claims and billing questions
- IVR eligibility capabilities
- Interactive website where you can access member eligibility and claims status information
- An award-winning Member Services department that works with our members to promote health education and health plan awareness
- A Special Needs Unit that helps members with special medical, behavioral and social conditions access their health care benefits and needed community resources
- Participation in a health plan that delivers a higher level of benefits to our members than they would receive under traditional public sector health plans.

With inclusion at the very heart of the Unison philosophy, we look forward to working with you to create a far-reaching health care network that is unyielding in its commitment to serving our members.

Unison Provider Services is pleased to answer any questions that you may have. Please call us at 800.600.9007. You can also learn more about Unison by visiting www.unisonhealthplan.com. Our website now features online services to help you check claim and eligibility status. You can also access and download the provider manual, locate important phone numbers and view important billing alerts.

1: Unison Health Plan Website

You can access Unison Health Plan’s website at www.unisonhealthplan.com by selecting Delaware from the *Select Your State* menu and Unison from the *Select Your Plan* menu.



Once you have selected Delaware and Unison, click on the *For Providers* tab located at the top of the page to access a menu with the following options:

- A *Find a Provider* feature that will let you easily locate other Unison participating providers
- A quick reference guide listing phone numbers and provider account, claims and service information
- Provider Relations team names and contact information
- A summary of member benefits and the member handbook
- Important forms, the provider manual, provider newsletter and EDI documentation
- Billing alerts and clinical guidelines.

Unison’s online provider portal now allows you to submit prior authorization requests for DME, inpatient services, home IV and infusion, and general outpatient and professional medical services online. To access this feature, you must create a free account by accessing the *Create an Account* feature under the *Account Information* link. Once you create an account, you can also check eligibility, claims, authorization and appeal status online.

2: Eligibility and Membership Information

2.1 Enrollment

Unison is only offered to eligible Medical Assistance (MA) recipients, as determined by the Department of Social Services. Enrollment for the managed Medicaid program is done by HBM. Once enrolled, the recipient will be pre-nominated by random assignment to a Medicaid or DHCP managed care plan. If the member does not respond within 30 days, the member will be auto-assigned to one of the state’s Medicaid plans. Members that are auto-assigned to a health plan have the option of changing their health plan for up to 90 days after enrollment.

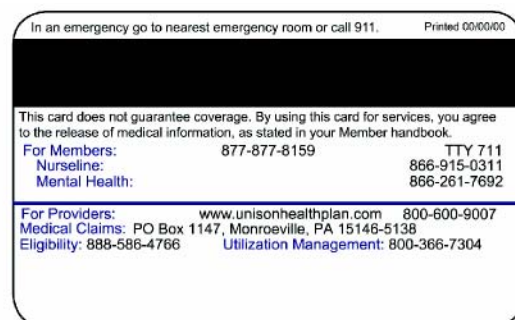
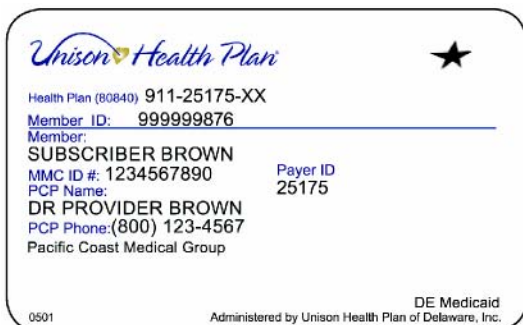
Under the program, an independent enrollment assistance program specialist is available in County Assistance Offices to distribute materials describing the Unison program and its benefits. Potential members meet with the enrollment representative to discuss rights and responsibilities of being a Unison Medicaid member. The potential member may choose to complete an application for enrollment. The enrollment broker submits enrollment applications to HBM for enrollment approval. HBM will then establish an HMO membership effective date. Initial effective dates will be the 1st of the calendar month following the receipt of enrollment application approval.

Open enrollment is held in May of each year, at which time clients may choose a health plan. Unison has a continuous enrollment process for new MMC enrollees who have been enrolled by HBM as noted above. Newborns may also be enrolled in Unison after notification of birth to HBM and completion of the enrollment process. Members may transfer to or from Unison for good cause, as determined by DMMA.

2.2 Member ID Cards

Every Unison member receives a personal member identification (ID) card. Even when more than one member of a family enrolls, Unison issues a separate ID card to each member. All member ID cards display the Unison logo, Member Services number, the PCP’s name and telephone number, the member’s name and the member’s Delaware Medicaid ID number. The back of the ID card lists the UM number, the claims submission address and instructions to members about accessing routine and emergency care.

The member should present his or her member ID card whenever seeking Unison covered services. No member should be denied services because of a failure to have a member ID card at the time of service, though. Providers can verify eligibility by calling 888.586.4766. A PCP who believes that an incorrect PCP name is listed on the member card can call the eligibility verification line to confirm the PCP and



verify the member’s eligibility. The following is an example of the Unison Delaware member ID card.

Delaware ID Card – Front

Delaware ID Card - Back

2.3 Eligibility Verification

The provider is responsible for checking the member's eligibility at the time of service. This includes eligibility with Unison and assignment to you as a PCP. To verify a member's enrollment in Unison and the member's PCP, providers can:

- Verify on the monthly member roster sent to PCP offices before the first of every month. New member additions to the practice will be indicated by an asterisk.
- Visit the Provider Account Information tool online at www.unisonhealthplan.com.
- Call Unison's Member Eligibility Verification IVR Line at 888.586.4766. The IVR Line can also provide COB information. Before calling, be sure to have your Unison provider number, the member's Unison ID number (or Social Security number) and the member's date of birth.
- Verify by electronic transaction using the inquiry service on the Unison Health Plan website, under Account Information. Please reference the instructions, entitled "Verify Reference ID Status Instructions" found in the *For Providers* section.

2.4 PCP Selection

Every member enrolling in Unison must select a participating PCP. PCP selection is encouraged and verified during the call that the Unison enrollment verification representative attempts to make to the member within one week of enrollment. The enrollment verification representative also verifies the member's demographic information and reinforces education of membership responsibilities, the role of the PCP and general health plan guidelines. If a new member does not select a PCP, Unison will assign the member to a PCP based on geographic location. The member may change this selection later for any reason.

Members may change their PCP at any time; although Unison encourages members to select a PCP they intend to remain with for an extended period of time. A member may change PCPs or verify that a requested change has occurred by calling Member Services.

2.5 PCP-Initiated Transfers

PCPs may recommend that a member be removed from their practice due to member non-compliance or a failure to establish a mutually beneficial relationship. The PCP must have made all reasonable efforts (three attempts within 90 days) to accommodate the member. The PCP may not use the member's health status as cause to transfer a member. The PCP must submit a written request to Provider Relations. Upon receipt of the request, Member Services will contact the member to facilitate selection of a new PCP. The representative will address educational issues as necessary. The new PCP effective date and a new member ID card are issued as soon as possible. The PCP may be required to provide care to the member for up to 30 days from Unison's receipt of the request or until a new PCP is chosen. A new PCP will be selected for the member if Unison is unable to contact the member via telephone. A letter is sent to the member indicating the name of the new PCP and the reasons for the change.

2.6 PCP Member Rosters

PCPs receive a monthly roster of members who have chosen their practice for primary care services. The lists are sent to PCP offices before the first of every month. New member additions to the practice will be indicated by an asterisk. Termination dates of members who are disenrolling from the plan or practice will also be indicated. Consulting providers and providers do not receive monthly rosters. Unison recommends that all PCPs, consulting providers and providers verify member eligibility prior to each

service. Unison offers eligibility verification by telephone using our Member Eligibility Verification Line, on the Unison website or by an electronic transaction system.

2.7 Member Rights

- To pick your own primary care physician (PCP) within the Unison provider network.
- To ask for and get information about Unison and information on how to use Unison benefits.
- To get quality health care services.
- To get good care and to be treated with respect and due consideration for your dignity and privacy.
- To know the names, titles and educational backgrounds of all physicians and others helping you.
- To understand your medical and health needs, what should be done for you, what choices you have and what risks are involved.

- To receive free language assistance if you speak another language or are hearing impaired.
- To say no to treatment and to take the responsibility for the consequences of saying no to treatment.
- To not have your medical records shown to others without your approval, unless permitted by law.
- To have your privacy respected during an office visit, when getting treatment or when talking to Unison.

- To look at all your medical records in accordance with applicable Federal and State laws and to have these records kept private.
- To ask that corrections be made to your medical records if you notice a mistake.
- To be told who has been given a copy of your medical records.
- To have an advance directive.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To share ideas to improve Unison Health Plan's procedures and policies.
- To get a second opinion from a qualified participating provider or a non-participating provider, if a participating provider is not available.
- To be told in writing when any of your covered services are reduced, suspended, terminated or denied.

- To file an appeal regarding any medical or administrative decisions if you disagree.
- To be sure that your PCP and the staff of Unison Health Plan know your rights.
- To have these rights regardless of gender, culture, economic status, education, race, ethnicity, age, national origin, sexual orientation, physical or mental disability, type of illness or condition, ability to pay, ability to speak English or religious background.
- To receive information on treatment options, alternatives and costs whether the treatment is covered by Unison or not.
- To know how Unison pays providers, controls costs and makes decisions about which services are covered.

- To get emergency care without having to get a prior approval when you have a true medical emergency.

2.8 Member Responsibilities

- To let Medicaid, Delaware Healthy Children's Program (DHCP) and Unison know if you or a family member changed a name, address or phone number
- To let Medicaid, DHCP and Unison know if you have a change in family size, if you or a family member loses a job or changes jobs, if a member becomes employed or if you have other health insurance
- To call the local Medicaid office in the county where you live and give them all of your new information if it changes.

- . To respect the doctors, staff and people giving you health care services.
- To be sure that you are the only one who uses your Unison identification card and to let Unison Health Plan know if it is lost or stolen.
- To be sure to show your Unison and Medical Assistance ID cards each time you have a doctor's appointment; if you have any other health care insurance, you must show your PCP the card for that too.
- To be sure to go to your assigned PCP for all of your non-emergency health care unless your PCP sends you to a specialist for care; if you are pregnant and do not wish to go to your PCP, you may go to an obstetrician/gynecologist who works with Unison Health Plan.
- To ask questions if you do not understand what the health care providers are saying to you.
- To answer all questions and provide all information about your health that will help your PCP take care of you.
- To follow instructions given to you by your PCP.
- To keep your scheduled health care appointments.
- To schedule and keep wellness check-ups, including EPSDT (WellChild) appointments for members under 21 years of age.
- To get care as soon as you learn you are pregnant and keep all pregnancy appointments.
- To give your doctor a copy of any advance directives, including a living will.
- To be on time and call your PCP's office at least 24 hours in advance, when possible, if you need to cancel an appointment.
- To let your PCP know when you went to the emergency room, or have someone do it for you, within 24 hours of emergency care.
- To let us know if you have another insurance company that is going to pay for your medical care for any reason (health, auto, home or workers' compensation, for example) To give your O.K. for us to use your health information.
- To give your O.K. for us to use your health information.

3: Participating Provider Responsibilities

3.1 General Requirements

In contracting with Unison Health Plan, all providers (practitioners, other health professionals, hospitals, facilities and agencies) agree to:

- **Never** bill or balance bill Unison members for covered services. Sending bills or balance bills to Unison members for covered services is a violation of your Participating Provider Agreement with Unison and violates Delaware law and regulation. Instruct your office staff to ask for appropriate documentation of a patient's insurance coverage and accurately maintain this information in all billing systems. If your office has not received payment for covered services provided to a Unison member, call 800.600.9007. Unison's participating providers may not seek compensation from a member unless:
 - > The member is informed in advance that a proposed service is not a covered benefit; and
 - > The member accepts financial responsibility, in a signed document that includes the services provided, the cost of non-covered services, notification that Unison will not pay or be liable for said services, and notification that the member will be financially liable for such services;
- Advise patients who request services not covered by Unison Health Plan of their financial obligation for those services prior to rendering them;
- Offer access to office visits on a timely basis in compliance with the standards in this manual;
- Maintain medical records and patient confidentiality as outlined in this manual;
- Maintain malpractice insurance, all licenses and certifications required to practice and render services without any encumbrances, limitations or restrictions and provide copies of such licenses and certifications to Unison for verification and (re)credentialing purposes;
- Provide covered benefits in a manner consistent with professionally recognized standards of health care and in accordance with standards established by Unison;
- Respect the rights of Unison Health Plan members;
- Coordinate and provide in-office interpretation services for members that speak languages other than languages that the provider speaks. Providers needing assistance in locating an appropriate interpreter may contact the SNU for assistance in securing an interpreter. If Unison provides an interpreter, either via a conference call or in person, Unison will pay the associated interpretation costs. However, the health care professional or facility must pay costs for any interpreter which Unison does not provide. Health care professionals or facilities cannot directly or indirectly impose a surcharge on an individual with limited English proficiency to offset the cost of the interpreter;
- Notify Unison of any change in office location, office hours or additional office locations at least 30 days prior to the date when services will be rendered at the new location(s);
- Notify Unison promptly of any changes in the information originally submitted in the application to participate in Unison Health Plan;
- Submit to Unison all data necessary to characterize the content and purpose of each member encounter. The submission of a claim or encounter information by a provider is the provider's certification that the information is accurate, complete and truthful;
- Never employ or contract with individuals who are excluded from participation in any public sector health plan or with entities that employ or contract with such individuals;
- Be aware and comply with the following:
 - > Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 C.F.R. Part 84
 - > The Age Discrimination Act of 1975, as implemented by regulations at 45 C.F.R. Part 91
 - > The Rehabilitation Act of 1973
 - > The Americans with Disabilities Act

- The informed consent procedures for hysterectomy and sterilization specified in 42 CFR, Part 441, sub-part F
- Other laws applicable to recipients of federal funds
- Standards set forth by the Unison Health Plan compliance program
- All other applicable laws and rules;
- Cooperate with and participate in Unison QI and UM programs; and
- Notify Provider Relations when members miss appointments. When a member misses an appointment providers should complete a Member Education form (located on our provider website at www.unisonhealthplan.com). Upon receipt of a Member Education form, Provider Relations will review the form and forward it to Member Services to contact the identified member and discuss the member's responsibilities regarding appointments.

3.2 Provider Office Standards

Unison requires that providers maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities Act (ADA) standards. Provider Relations representatives conduct site visits to ensure that each PCP office meets ADA standards. If a PCP is planning to relocate an office, a Provider Relations representative must perform a site visit before care can be rendered at the new location.

3.3 Allowable Office Waiting Times

The member's wait time should be no more than 45 minutes or up to one hour when the provider encounters an unanticipated urgent visit or is treating a member with a difficult medical need. Emergency cases should be seen immediately.

All primary care providers (PCPs) are contractually required to be available to their members 24/7 to make certain the members have timely access to necessary care, including emergency care, and to allow the PCP to continue to act as the medical home. Offices must have a phone message or answering service available to members after office hours that instructs the member on how to contact the provider for urgent or emergency conditions.

3.4 Charging Medicaid Clients for Missed Appointments

CMS prohibits providers from billing Medicaid clients who miss scheduled appointments. This policy is based on the fact that a missed appointment is not a distinct reimbursable Medicaid service, but a part of the provider's overall costs of doing business. The Medicaid rate covers the cost of doing business, and providers may not impose separate charges on Medicaid clients.

3.5 Medical Records and Charting Standards

The Unison QI program confirms that medically necessary services are provided to members in both a timely and confidential manner. Medical records must be maintained in a manner that is current, detailed and organized and that permits effective and confidential patient care and quality review. The Medical Record Documentation Standards were developed by Quality Improvement and approved by the Unison EQIC and board of directors.

Per the Unison provider agreements, all records, including medical records and financial documents, must be maintained and available for review, audit or evaluation by authorized state personnel or their representatives. Providers must retain the source records for operational data reports for a minimum of seven years and have written policies and procedures for storing such information.

PCPs, OB/GYN providers and other high-volume consulting providers are evaluated on the medical record standards at the time of initial credentialing and every 24 months. Providers will receive feedback at the conclusion of the audit indicating the level of compliance with Medical Record Documentation Standards. The score required to pass is 80% or greater. The reviewers will give clear and concise instructions to the provider via the feedback form, which serves as a corrective action plan for any noted deficiencies.

The initial review includes an evaluation of the medical record keeping practices. Subsequent reviews evaluate the adequacy of completed medical records. Up to 10 medical records of various patient ages will be reviewed for each practice. The reviewer will investigate the quality of care, the continuity and coordination of care, under- and over-utilization and preventative health care, as well as other medical recording keeping practices.

3.5.1 Standards by Demographics

- Each page of a medical record should contain a name or medical record number as an identifier.
- A mailing address where the patient can be reached should be noted as well as the home phone number. If there is no phone, a neighbor, family member or friend should be listed.
- Birth date should be documented in the medical record.
- An emergency contact name and phone number should be listed in the medical record.
- The patient's gender should be noted.
- Each entry needs to contain the author's electronic, hand-written or initialed signature.
- All entries in the medical record should be dated.
- The medical record should be legible to someone other than the writer. If questionable, Unison reserves the right for medical records to be released to our medical director for review.

3.5.2 Standards by Patient History

- Each medical record should contain a problem list. This area, where significant illnesses or medical conditions are documented, should be updated frequently to show both active and inactive conditions.
- A medication list should be incorporated into the charting system. This section should be a current list of maintenance type medications.
- Allergies need to be noted in a prominent place in the chart. Such prominent areas could be the covers of the chart or an area easily identified when the chart is opened. If the patient has no allergies, then "NKA" needs to be documented.
- There should be a detailed past medical history including illnesses, operations, injuries, disabilities, family history and any information pertinent to the patient's health.
- A medical record should contain documentation that smoking, alcohol and substance abuse have been addressed. If the patient is under 12 years old, documentation should be related to smoking in the home. If the patient is 12 years and older, documentation should be patient-specific.

3.5.3 Standards by Diagnosis and Treatment Plan

- Lab and other studies that are ordered must be appropriate to patient symptoms and physical findings.
- Documents should include subjective and objective data.
- Working diagnoses should be consistent with physical, X-ray, lab and consult findings.
- Action and treatment plans should be consistent with diagnoses.
- Follow-up visits should be documented in days, weeks or months when clinically appropriate. Follow-up visits can be noted in the chart, appointments scheduled at time of visit, a reminder card system or a super billing system.

. Unresolved problems from previous visits should be documented in the subsequent visit.

3.5.4 Standards by Continuity

- There should be evidence to support the use of consultations.
- If referred to by the primary doctor, documentation of the consulting provider's findings, skilled nursing facility progress notes or discharge summaries, inpatient discharge summaries and home health care notes and discharge summaries should be noted in the medical record.
- All consults, summaries, lab and imaging studies need to be initialed or have explicit notation of review in the medical record.
- Abnormal labs, consults, imaging studies and summaries should have explicit notations of a follow-up treatment plan.
- There should be no evidence that the patient is placed at inappropriate risk by a treatment plan.

3.5.5 Standards by Prevention

- A completed immunization record should be present in all children's medical records, including a notation of chicken pox history or vaccination.
- Height, weight and BMI should be noted.
- An appropriate immunization record should be present in adult medical records.
- Preventive health issues should be appropriately addressed in the medical record and are audited using the applicable Preventive Health audit tools. These preventive health guidelines by age appropriateness are located at www.unisonhealthplan.com. Select *Delaware* and *Medicaid*, then click on the *For Providers* tab at the top of the page. The guidelines are available by clicking on the *Clinical Guidelines* link in the left-hand menu.
- Documentation of the presence or absence of an advance directive should be present on the chart.
- There should be evidence of patient teaching.

3.6 Requests for Medical Records

Each member is entitled to one free copy of his or her medical records. Members can request additional copies; the fee for additional copies cannot exceed the actual cost of time and materials used to compile, copy and furnish these records. When a member changes PCPs, the current PCP must forward the member's medical records or copies of the medical records to the new PCP within ten business days from receipt of request.

3.7 Access and Safety Review

When medical records are reviewed, Unison QI nurse reviewers will also assess compliance with appointment access standards and patient safety regarding treatment and medication safety. This focused review will also be discussed with the office staff and recommendations for improving deficiencies will be noted. Those providers falling below the acceptable level of 80% will be referred to the medical director for further action. Both the medical record review and the focused access/safety review will become part of the provider's credentialing file.

3.8 Credentialing Standards

Unison will credential and re-credential all participating providers according to the regulations set forth by the State of Delaware, Department of Health. The following key elements are required to begin the credentialing process:

- . A completed credentialing application including a signed attestation
 - Copy of current medical license
 - Copy of current DEA certificate
 - Copy of the malpractice certificate of insurance showing the policy number, coverage limitations and expiration dates
 - Copy of current W-9 form
 - NPI number
 - Program integrity ownership, control and criminal history disclosures (CMS form 1513 and Unison's Individual Practitioner Attestation)
 - Medicaid ID number (when applicable).

Information from primary sources regarding clinical privileges, education and training, board certification and malpractice claims history will be verified as part of the credentialing process.

3.9 Facility Review

Unison has established specific guidelines for conducting an initial facility review, including medical record keeping practice standards, at primary care and OB/GYN offices. The purpose of the facility review is to confirm that providers comply with the Unison facility standards. Each facility review will measure accessibility, availability of appointments and adequacy of waiting and examining room space. The score required to pass is 80%. Providers who meet the credentialing criteria will be submitted to the Credentialing Committee for approval. The committee will provide final decision to accept or reject the credentialing application. Upon committee approval, providers will be notified of their participation status, effective date and provider ID numbers.

3.10 Adverse Credentialing

Providers that do not meet the criteria set forth by the Credentialing Committee will be notified in writing via certified mail. The letter will define the committee's determination, along with the right to appeal and a copy of the appeals process. Possible factors that would prohibit a provider from meeting the committee's criteria include a lack of admitting privileges to a Unison participating hospital or not meeting baseline criteria of license, education or board certification. Section 17.5 of this manual provides instructions if you disagree with the decision of the credentialing committee or if you wish to appeal the decision.

3.11 Re-Credentialing

The re-credentialing process will be conducted at least every three years for PCP and OB/GYN practices. The process will include evaluation of the following key elements:

- A completed re-credentialing application including signed attestation
- Copy of current medical license
- Copy of current DEA certificate
- Copy of the malpractice certificate of insurance showing the policy number, coverage limitations and expiration dates
- Member complaints and satisfaction
- QI activities
- Encounter claims data audit
- UM information
- Review of sanctions.

Providers who meet the re-credentialing criteria will be submitted to the Credentialing Committee for approval. The committee will provide final decision to accept or reject the re-credentialing application. Upon committee approval, providers will be notified of their participation status. Providers not meeting these criteria will be notified and may appeal the decision as outlined above.

3.12 Cultural Competency

As a company dedicated to managing the health of beneficiaries of public sector health care programs, Unison recognizes the importance of serving members in a culturally and linguistically appropriate manner. Unison knows from direct experience that:

- some members have limited proficiency with the English language; this includes members whose native language is English but who are not fully literate;
- some members have disabilities or cognitive impairments that impede their communicating with the health plan or providers and their use of health care services;
- some members come from other cultures that view health-related behaviors and health care differently than the dominant culture; and
- some members from economically disadvantaged segments of society have faced longstanding barriers to good health and thus exhibit disproportionately high rates of certain diseases.

Unison recruits a diverse array of providers to ensure that our network is built around “significant traditional providers” to reflect the needs of the population served. Our providers and support services value diversity and are committed to serving people of racial and ethnic minorities. Though it is unlikely that the make-up of the provider network will reflect the composition of the enrolled population exactly, Unison strives to achieve the best possible match in each community.

Language is often cited as a barrier to accessing appropriate health care. To address this concern, our providers must offer interpretation services to our members. Providers that encounter language barriers can call Provider Services or the Special Needs Unit (SNU) for assistance.

3.13 Advance Directives

The adult member has the right to make health care decisions and to execute advance directives. An advance directive is a formal document that the member prepares in advance of an incapacitating illness or injury. The provider should be aware of and maintain a copy of the member’s completed advance directive in the patient’s medical record, but should not send a copy to Unison. Members are not required to initiate an advance directive and cannot be denied care if they do not have an advance directive.

If a member believes that a provider has not complied with an advance directive, s/he may file a complaint with a medical director or Unison representative. Unison will notify members in writing of any changes to laws and regulations governing advance directives as soon as possible (but no later than 90 days after the effective date of the change). For additional information about advance directives, please contact:

Division of Services for Aging and Adults with Physical Disabilities
Main Administration Building
1901 N. DuPont Highway
New Castle, DE 19720
Phone: 800.223.9074

4: Primary Care Provider Policies

4.1 Role of the Primary Care Provider (PCP)

The PCP plays a vital role as a physician care manager in the Unison system by improving health care delivery in four critical areas: access, coordination, continuity and prevention. The PCP is the point of entry into the delivery system – except for services allowing self-referral, emergencies and out-of-area urgent care – and is the medical home for all members on the PCP’s roster.

The PCP responsible for the provision of initial and basic care to members who have selected the PCP and makes referrals as required for specialty and ancillary care and coordinates all care delivered to members. Unison expects PCPs to communicate with specialists the reason for all referrals by use of a prescription or letter and to note this in the patient’s medical record. Unison expects a specialist to communicate to the PCP significant findings and recommendations for continuing care. A specialist may not refer the patient directly to another specialist.

Unison works with members and providers to ensure that all participants understand, support and benefit from the primary care system.

4.2 24/7 Availability

PCPs must be available to members by telephone 24/7 or have arrangements for telephone coverage by another Unison participating PCP. A medical director must approve coverage arrangements that vary from this requirement. PCPs are expected to respond to after-hours patient calls within 30 to 45 minutes for non-emergency symptomatic conditions and within 15 minutes for crisis situations. Unison tracks and investigates all instances of PCP inaccessibility. Unison also conducts periodic access surveys to ensure that all access standards are met. PCPs are required to participate in all activities related to these surveys.

4.3 Responsibilities of the PCP

In addition to the requirements applicable to all providers (see Section 3), the responsibilities of the PCP include providing primary and preventive health care services and acting as the member’s advocate in recommending and arranging care, based on medical necessity. Determinations of medical necessity for covered care and services, whether made on a prior authorization, concurrent review or post-utilization basis, must be in writing and be covered by the Unison fee schedule. Unison will base its determination on medical information provided by the member, the member’s family/caretaker and the PCP, as well as any providers, programs or any other agencies that evaluate the member. Medical necessity determinations will be made by qualified and trained providers.

Satisfaction of the following standards will result in authorization of the service for Unison Medicaid members:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- The service or benefit will help the member achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.

Other PCP responsibilities include:

- Maintaining continuity of member's health care;
- Directing care to participating providers and emergency care facilities;
- Maintaining, copying or forwarding a member's medical record and documenting all services provided to the member. The record must note the execution of advance directives for all adult patients. An advance directive constitutes written instruction, such as a living will or durable power of attorney, relating to the provision of health care if the patient is incapacitated;
- Demonstrating a willingness and ability to make distinctions between treatment methods consistent with the member's cultural background and maintaining consistency in providing quality care across a variety of cultures;
- Having a process to allow use of TTY or language assistance for members;
- Coordinating behavioral health services; and
- Complying with the Unison Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for children up to age 21.

As agreed upon in the PCP agreement with Unison, the PCP will:

- not differentiate or discriminate in the treatment of his or her members in the quality of services delivered to members on the basis of race, color, age, national origin, religion, economic status, source of payment, health status or health care needs; and
- observe, protect and promote the rights of members as patients. The PCP agrees to maintain a written sexual harassment policy and will inform its employees of the policy.

Pursuant to regulations promulgated under the authority of the Americans with Disabilities Act, 28 C.F.R. 35.101 et. seq., the PCP understands and agrees that no individual with a disability will, on the basis of the disability, be excluded from participation in the PCP agreement or from activities provided for under the PCP agreement. As a condition of accepting and executing the PCP agreement, the PCP agrees to comply with the "General Prohibitions Against Discrimination," 28 C.F.R. 35.130, and all other regulations promulgated under Title II of the Americans with Disabilities Act that are applicable to the benefits, services, programs and activities provided by government agencies with whom Unison has entered into a contract for the provision of health care services, including guidelines issued by the governing regulatory agencies.

Unison Medicaid providers must abide by Delaware state laws and the relevant department regulations of the Delaware DOH and DMMA accessibility standards:

- Emergency appointments must be scheduled immediately or referred to an emergency facility (i.e. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room visits). If emergency care is denied, the member must be seen at once by the PCP or referred to an open urgent care clinic.
- Urgent appointments must be scheduled within 2 calendar days (i.e. persistent rash, recurring high-grade temperature, nonspecific pain, fever).
- Routine/Preventive care appointments must be scheduled within 3 weeks of member request.
- EPSDT and child preventive care appointments must be scheduled within 2 weeks of member request.

[4.4 PCP Selection](#)

Every member enrolling in Unison is required to select a participating PCP. Members may change their PCP at any time; although Unison encourages members to select a PCP they intend to remain with for an extended period of time. PCP selection is encouraged and verified during the call that the Unison



enrollment verification representative attempts to make to the member within one week of enrollment. The enrollment verification representative also verifies the member's demographic information, reinforces education of membership responsibilities, the role of the PCP and general health plan guidelines. If a new member does not select a PCP, Unison will assign the member to a PCP based on geographic location. The member may change this selection later for any reason.

4.5 Member Encounters

PCPs are required to report to Unison all services they provide for Unison members. PCPs must submit patient encounters on a CMS 1500 or a UB-04 claim form or electronically within 90 days of the service date. This information is evaluated for utilization purposes and is required by our government sponsors. In accordance with the provider assessment guidelines, providers will make medical records and financial statements available to a clinical nurse reviewer for a member encounter audit.

4.6 Transfer of Non-Compliant Unison Members

PCPs may recommend that a member be removed from their practice due to member non-compliance or a failure to establish a mutually beneficial relationship. The PCP may not use the member's health status as cause to transfer a member. The PCP must submit a written request to Provider Relations. Upon receipt of the request, a Member Services representative will contact the member to facilitate selection of a new PCP. The representative will address educational issues as necessary. The new PCP effective date and a new ID card are issued as soon as possible. The PCP is required to provide care to the member for up to 30 days from Unison's receipt of the request or until a new PCP is chosen. The PCP must participate in the transition of the care plan. A new PCP will be selected for the member if Unison is unable to contact the member via telephone. A letter is sent to the member indicating the name of the new PCP and reason(s) for the change.

4.7 Second Opinions

Members may ask for and receive a second opinion from a qualified, Unison-participating provider or a non-participating provider, if a participating provider is not available, for any diagnoses that they receive from PCPs or specialists.

4.8 PCP Compensation

Unison's PCP compensation plans are designed to compensate PCPs for the services they are contractually obligated to provide and to encourage the delivery of preventive services and the documentation of encounters through financial incentives. To further ensure quality, there are no incentives (such as withholds) to reduce or deny services.

5: Specialist Provider Standards and Policies

5.1 Responsibilities of Specialty Providers

In addition to the requirements applicable to all providers (see Section 3), the responsibilities of specialist providers include the following:

- Offer access to office visits on a timely basis according to the standards outlined in this manual.
- Provide specialty medical services to Unison members who are directed by the member's primary care provider (PCP) or who self-refer.
- Refer services requiring prior authorization to UM as appropriate. Unison recommends calling at least 72 hours in advance of the admission or surgery. A provider may appeal any adverse decision made by Unison. Procedures for filing an appeal are detailed in each specific plan's section of this manual.
- Provide the PCP copies of all medical information, reports and discharge summaries resulting from the specialist's care.
- Communicate in writing to the PCP all findings and recommendations for continuing patient care and note them in the patient's medical record.
- Maintain staff privileges at a minimum of one Unison-participating hospital.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws and regulations.

5.2 Specialist Access Standards

Specialists are required to adhere to the following access standards:

- Emergency care appointments must be scheduled immediately
- Urgent care appointments must be seen within 48 hours of referral.
- Routine appointments for patients must be seen within 3 weeks of referral.

5.3 Specialists as PCPs

To assist our members with complex illnesses or conditions that require frequent visits to a specialist, care may be improved by having a specialist serve as a member's PCP. If you are a specialist who receives frequent requests for a member with special health care needs, believe that the member's care may be enhanced by your serving as his or her PCP and can be available to the member 24/7, please call the Special Needs Unit at 877.844.8844. A Unison medical director will review the case and, if necessary, begin the credentialing process to all allow you to serve as the member's PCP.

5.4 Member Notification of Terminations

At least 30 days prior to the effective date of your termination or your group's termination from the network, Unison will send, via regular mail, notification to our affected members/your patients. Your affected patients/our members will include those Unison members for whom a claim was filed on your behalf or on behalf of your medical group within the six months prior to the effective date of termination or departure.

6: Emergency and Hospital Provider Policies

6.1 Emergency Medical Conditions

An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction to any bodily organ or part.

6.1.1 Medical Emergency

A member may self-refer for an emergency as defined above. PCP authorization is not required prior to medical emergency treatment. However, Unison recommends that the facility or member notify the PCP of the incident within 24 hours.

6.2 Emergency Ambulance Services

Ambulance services are covered in emergency situations. Members may access immediate medical transport in true medical emergencies, as well as for non-emergency facility-to-facility transports. Medical transport for non-emergency cases (except facility-to-facility transports) is covered by DHSS.

6.3 Emergency Room Services

In non-emergency cases, members are required to contact their PCP prior to visiting an emergency room. The facility should verify member eligibility as soon as possible after a visit to the emergency room.

6.3.1 Emergency Inpatient Admissions

Authorization is not required if a member is treated for a medical emergency as defined in the provider contract. However, Unison providers are required to notify UM within 48 hours, the next business day or after post-stabilization of a hospital admission arising from an emergency medical condition. If the admission/surgery is approved, UM will issue the certification to the appropriate party. Any requests that do not meet Unison's criteria or which are not addressed by these criteria will be referred to the medical director for further review.

6.3.2 Non-Emergency Inpatient Admissions

In order for Unison to monitor the quality of care and utilization of services by our members, all Unison providers must obtain prior authorization by contacting UM for all hospital admissions not meeting the definition of an emergency medical condition. Unison will accept prior authorization requests for non-emergency services from the PCP or ordering provider. No party should assume the other has obtained prior authorization. The requesting provider should make every attempt to request the above prior authorization at least 72 hours prior to admission.

6.3.3 Hospital Transfers

In the event of a transfer to another facility, the transferring facility or attending provider must contact UM prior to the transfer. No party should assume that another party has obtained prior authorization.

6.4 Outpatient Services

Please see the Benefit Grid to determine appropriate authorization requirements based upon the type of service. Upon receiving outpatient services, if a member's condition requires immediate admission, prior authorization must be obtained. The admitting facility must contact UM within 48 hours or the next business day. In the event that a Unison Medicaid member is admitted due to complications of an outpatient surgery, the SPU charges and inpatient services must be billed separately. Please be sure that all claims include your appropriate provider ID numbers and appropriate authorization information for each place of service.

6.5 Inpatient Concurrent Review

UM must monitor the progress of members throughout the inpatient stay. This is accomplished by UM receiving clinical information from the hospital on a clinically appropriate basis that details the member's progress to date. UM monitors appropriateness of continued inpatient stay according to established criteria under the direction of the Unison medical director. As part of the concurrent review process, UM coordinates the discharge plan and assists in arranging additional services, special diagnostics, home care and durable medical equipment.

6.6 Home Health Services

Upon discharge, home health care services and related durable medical equipment must be prior authorized through UM as necessary.

6.7 Skilled Nursing Units

Unison providers may use a skilled nursing unit only when prior authorized by UM. The ordering provider or the discharging facility may make the request for such prior authorization. The requesting provider should make every attempt to make the above prior authorization request at least 72 hours prior to admission. **Please note:** Unison is financially responsible for the first 30 inpatient days of medically necessary skilled nursing care provided in a Medicaid-approved facility for Unison members with or without an additional primary insurance carrier.

6.8 Inpatient Rehabilitation Unit

Unison providers may use an inpatient rehabilitation unit only when prior-authorized by UM. The ordering provider or the discharging facility may make the request for such prior authorization. The requesting provider should make every attempt to make the above prior authorization request at least 72 hours prior to admission.

6.9 Difference in Coverage for Unison Medicaid Members during Inpatient Admissions

Previously, when a member was admitted to a hospital under the fee-for service (FFS) health care delivery system and then assumed MCO coverage while still in the hospital, the FFS health care delivery system was responsible for the hospital bill through the date of discharge, including any transfers to another hospital (PT 11, 12 or 13). On the effective date of MCO coverage, the MCO health care delivery

system was responsible for provider services, durable medical equipment (DME) and all other covered services not included in the hospital bill.

When a recipient is admitted to a hospital under the FFS delivery system and assumes MCO coverage while still in the hospital, but is then discharged or transferred from the initial inpatient hospital to another hospital (provider type 11, 12 or 13) after the MCO effective date, then the FFS delivery system is responsible for the inpatient hospital bill covering the initial hospital stay only from the admission date through the date of discharge (on the effective date of MCO coverage, the MCO delivery system is responsible for provider services, DME and all other covered services not included in the initial inpatient hospital bill). The MCO delivery system assumes responsibility for the subsequent hospital bill upon admission.

Example:

- Recipient enters Hospital “A” on January 15 under the FFS delivery system.
- MCO coverage becomes effective on February 1 – the MCO delivery system becomes responsible for provider services, DME and all other covered services not included in the Hospital “A” bill.
- Recipient transfers from Hospital “A” to Hospital “B” on March 1.
 - The FFS delivery system is responsible for the entire Hospital A bill through the date of discharge on March 1.
 - The MCO delivery system is responsible for the Hospital “A” bill upon admission on March 1.

7: OB/GYN Provider Policies

7.1 Role of the OB/GYN

To enhance access to OB/GYN services and promote the highest level of care coordination, Unison members to self-refer to any participating OB/GYN provider for an annual exam, suspected pregnancy or any other medical visit. Unison permits PCPs to perform routine gynecological exams, Pap smears and provide pregnancy care if they are credentialed by Unison to provide these services.

7.2 OB/GYN Responsibilities

- Notifying the PCP of the treatment plan and the estimated duration of specialty or prenatal care. The OB/GYN may use established means of communicating this information.
- Arranging and ordering medically appropriate services.
- Complying with Unison's administrative prior authorization and member self-referral guidelines.
- Maintaining a member's medical record documenting all specialty services provided to the member.
- A willingness and ability to make distinctions between treatment methods consistent with the member's cultural background and to maintain consistency in providing quality care across a variety of cultures.
- Providing care to members without regard to race, color, creed, sex, religion, age, national origin, marital status, sexual orientation, language, health status, pre-existing conditions and physical or mental handicap.

7.3 Family Planning Services

Unison members may self-refer for family planning services, including contraceptive care and urine pregnancy tests. Unison members may self-refer to any provider in or out of Unison's provider network to provide family planning services. There is no limit to the number of family planning visits a Unison member may have in a calendar year.

7.4 Abortions

Abortions are covered by Medical Assistance under either of the following conditions:

- A provider must certify that due to a condition, illness or injury, an abortion is necessary to avert the woman's death.
- The woman was a victim of rape or incest that was reported to a law enforcement agency prior to the performance of the abortion, unless a provider certifies that, in his/her professional judgment, the patient was physically or psychologically unable to report the crime. In cases of incest where the victim is under 18 years of age, the incident must also have been reported to the Department of Services for Children, Youth and Their Families. The identity of the offender must have been reported by the victim of rape or incest, if the identity is known.

The treating provider must complete an Abortion Justification Form, which can be found on the Unison website, for all abortions. In addition to the abortion Justification Form, the treating provider must attach the complete medical record to the CMS 1500. It is the responsibility of the treating provider to supply a copy of the Abortion Justification Form and the complete medical record to the hospital and the anesthesiologist for their billing purposes, if needed.

7.5 Sterilization

Unison members may elect for outpatient sterilization surgery. Prior authorization must be obtained once the Sterilization Consent Form (MA3 1) has been signed and submitted with the claim and the 30-day waiting period has expired. According to state guidelines, Unison members only have 180 days to act from the date of the signature on the consent form.

Contact UM to prior-authorize tubal ligations. This authorization will be added to the pregnancy authorization. The Sterilization Consent Form (MA 31) has to be completed and signed and the 30-day waiting period must expire prior to contacting UM.

7.6 Gynecological Services

All Unison members may self-refer for annual gynecological exams, mammograms and Pap smears to any Unison participating provider contracted to provide gynecological services. Gynecology providers may order related diagnostic tests such as mammograms and Pap smears. The gynecological provider must refer the member back to the PCP for services unrelated to the gynecological diagnosis. Per Delaware law, OB/GYN physicians may serve as primary care providers.

7.7 In-Office Surgery

Any surgeries that are performed in the office by the gynecological provider do not require any additional authorizations from the PCP prior to rendering services.

7.8 Hysterectomy

Unison members who are undergoing a hysterectomy should sign the Patient Acknowledgement for Hysterectomy Form (MA 30). Unison members undergoing sterilization should sign the Sterilization Consent Form (MA 31). Providers are required to submit a copy of these forms to Unison. Copies of these forms should be retained in the member's medical record.

7.9 Obstetric Services

A member may self-refer for obstetric services to any Unison participating provider contracted to provide obstetrical services. An OB Needs Assessment Form must be completed as part of routine prenatal care to identify conditions that may place the member at risk of an adverse pregnancy. The OB Needs Assessment Form is located at www.unisonhealthplan.com. We cooperate with the state of Delaware Smart Start program, which includes services such as skilled nursing services at home. Smart Start visits may be requested by calling Care Management. The obstetrician should evaluate OB needs by using the criteria indicated on the OB Needs Assessment form. A copy of the OB Needs Assessment Form must be faxed or sent to the pregnancy care manager within 15 days from the initial assessment.

Please note that OB needs should be assessed throughout the course of the member's pregnancy. Consult the instructions on the back of the form for completion frequency. In addition, the OB Needs Assessment Form may be submitted to the pregnancy care manager at any time during prenatal care if a member's condition constitutes a change of the risk status. Each needs assessment request will be evaluated to identify the risk status of the pregnancy. The member's PCP must be notified of the pregnancy.

Unison requires an authorization for all inpatient stays, including delivery. For emergency admissions that do not result in a delivery, Unison requests that UM be contacted for authorization of admission within 48 hours of admission or the next business day. Unison requests that the provider completes the Maternity

Outcome Authorization Form within 48 hours of discharge.

During the course of the pregnancy, the obstetrician may perform services such as ultrasounds and fetal non-stress tests in the office setting or refer to a participating hospital. Routine prenatal care guidelines are outlined in this manual. When ordering specialized services, the obstetrician must follow Unison’s administrative policies for referred services and prior authorizations.

7.10 Maternity Appointment Access Standards

Prenatal care appointments must be accessible within the following time frames:

- First trimester appointments must be scheduled within 3 weeks of request.
- Second trimester appointments must be scheduled within 7 calendar days of request.
- Third trimester appointments must be scheduled within 3 calendar days of request.
- High-risk pregnancy appointments must be scheduled within 3 calendar days of identification of a high risk. If an emergency exists, then the member must be seen immediately.

7.11 Pregnancy Care Management

UM will provide care management services for members who are at risk of an adverse pregnancy. Regardless of risk status, a member may require additional services to assure a safe and healthy delivery. Listed below are some of the options obstetricians can choose for their patients:

- | | |
|-----------------------------------|--------------------------------|
| • Non-stress test (NST’s) | • Postpartum visit |
| • Contraction stress test (CST’s) | • Pap smears |
| • Amniocentesis | • Versions (positioning fetus) |
| • Ultrasounds (except for 3D) | • Genetics and counseling |
| • C-sections | • RH factor – RhoGAM |
| • Nutritionist | • Maternal fetal specialist |

Members are eligible for a postpartum home visit within two weeks of delivery. Subsequent home visits must be authorized by UM. The postpartum home visit is coordinated by UM upon discharge from the delivering facility. Please call Pregnancy Care Management if you have questions regarding other services at 877.844.8844.

7.12 Healthy First Steps Program

The Healthy First Steps program is a non-clinical program implemented by Care Management. The goal of the program is to assist members in every aspect of prenatal care to ensure a safe and healthy delivery. A Healthy First Steps representative will maintain regular contact with an expectant mom to develop a relationship throughout prenatal care. During this time, the Healthy First Steps representative will address issues such as the member’s pregnancy history and current environmental situation. The representative will assist with scheduling prenatal appointments and arranging for transportation when needed.

8: Ancillary Provider Policies

8.1 How to Arrange for the Delivery of Ancillary Services

Unison offers ancillary or supplemental services to compliment the benefit packages available through Unison. Information about how to arrange for these services is found below.

8.1.1 Ambulance Services

Ambulance services are covered in emergency situations and non-emergency facility-to-facility transports. In non-emergency cases, Unison providers should contact UM for prior authorization, except for facility-to-facility transports.

8.1.2 Vision Services

Unison has contracted with March Vision to manage its eye care benefit for Unison members. The provider directory lists participating March Vision providers. Member inquiries regarding vision care may be directed to Member Services. Provider inquiries regarding vision care may be directed to March Vision at (888) 493-4070.

8.2 Imaging Services

8.2.1 Imaging Ordered by the PCP

Please refer to the prior authorization table for a list of imaging services that require authorization. The PCP may direct a member to any Unison participating hospital, independent licensed imaging facility or portable imaging company for outpatient imaging services. The PCP must contact UM for imaging services requiring a prior authorization.

8.2.2 Imaging Ordered by the Consulting Provider

Consulting providers may perform or order any outpatient imaging services. The PCP referral authorizes the consulting provider to perform imaging services within the office setting. The consulting provider may direct a member to any Unison participating hospital, independent licensed imaging facility or portable imaging company for outpatient imaging services. The consulting provider must contact UM for imaging services requiring prior authorization.

8.3 Laboratory Services

8.3.1 Participating Laboratories

Unison participates with Lab Corp for laboratory services. In accordance with our existing outpatient laboratory policy, all outpatient lab services, **excluding** hematology/oncology, dialysis, family planning and obstetrical laboratory services (self-referred) must be rendered at a participating laboratory. Prior authorization may be required for some outpatient laboratory services.

8.3.2 Pre-Admission Laboratory Services

Laboratory services required prior to a facility admission or outpatient surgery should be performed by a participating laboratory. If the tests are performed by the admitting facility within 72 hours of the

admission or surgery, payment for those services will be included in the inpatient or surgery payment. If the labs do not fall within the 72-hour period, prior authorization is required. The ordering provider is responsible for obtaining the prior authorization.

8.4 Ancillary Services Without Valid Codes

Unison recognizes that some requested services do not have valid codes. Any item that does not have a valid code must be prior authorized through UM. In addition to a completed Prior Authorization Program Exception Form, the following information should be submitted by the ordering provider for the determination of medical necessity:

- Common or brand name of the item
- Date of service
- Diagnosis
- Number of units being requested
- Definition of a unit (i.e. per each, per box, per case)
- MSRP per unit
- Total charges for supplies
- Copy of manufacturer's specification sheet, if available
- Appropriate HCPCS code or Medicare code, if available
- All treatment the member has received for his or her medical condition.

9: Summary of Benefits

Please note that all benefits listed below are subject to Unison policies and procedures.

Benefits	Medicaid	DHCP
Abortion	Covered* (under certain circumstances; consent form required)	Covered* (under certain circumstances; consent form required)
Acupuncture	Not Covered	Not Covered
Allergy Testing	Covered	Covered
Behavioral Health (partial hospitalization, intensive outpatient)	Adults (18 & Above)* 20 Visits Per Year Children (17 & Under)* 30 Visits Per Year	Children (17 & Under) Covered by DSCYF
Behavioral Health - Inpatient (mental health and substance abuse)	Adults (18 & Above)* 30 Days Per Year** Children (17 & Under) Covered by DSCYF	Adults (18 & Above)* 30 Days Per Year** Children (17 & Under) Covered by DSCYF
Behavioral Health - Outpatient (mental health and substance abuse)	Adults (18 & Above) 20 Visits Per Year Children (17 & Under) 30 Visits Per Year	Adults (18 & Above) 20 Visits Per Year Children (17 & Under) 30 Visits Per Year
Behavioral Health - Residential Treatment Facility	Adults (18 & Above)* 60 (RTF) Days Per Year*** Children (17 & Under) Covered by DSCYF	Children (17 & Under) Covered by DSCYF
Bone Mass Measurement* (bone density)	Covered*	Covered*
Bony Impacted Wisdom Teeth Removal	Covered*	Covered*
Care Management	Covered	Covered
Chemotherapy (under \$250)	Covered	Covered
Chemotherapy (over \$250)	Covered*	Covered*
Chiropractic Services	Not Covered	Not Covered
Colorectal and Prostate Screenings	Covered	Covered
Dental Services	“Wrap-Around Service”	“Wrap-Around Service”
Diabetic Education	Covered	Covered
Diabetic Supplies and Equipment (under \$300)	Covered	Covered
Diabetic Supplies and Equipment (over \$300)	Covered*	Covered*
Dialysis (at participating facilities)	Covered	Covered

Benefits	Medicaid	DHCP
Dialysis (at non-participating facilities)	Covered*	Covered*
Durable Medical Equipment (under \$300)	Covered	Covered
Durable Medical Equipment (over \$300)	Covered*	Covered*
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Covered	Covered
Emergency Medical Transportation	Covered	Covered
Emergency Room Care	Covered	Covered
Eye Tests – Routine	Covered	Covered
Family Planning Services	Covered	Covered
Genetic Testing (including chromosome analysis)	Covered*	Covered*
Hearing Aids and Batteries	Adults (Over 21) Not Covered Children (Under 21) Covered	Adults (Over 21) Not Covered Children (Under 21) Covered
Hearing Exams	Covered	Covered
Home Health Care	Covered*	Covered*
Hospice Care	Covered*	Covered*
Imaging (CT, MR, PET, SPECT office cardiac nuclear studies)	Covered*	Covered*
Infertility Testing and Services	Not Covered	Not Covered
Inpatient Hospitalization (acute care)	Covered*	Covered*
Lab Tests and X-rays	Covered	Covered
Mammograms (screening)	Covered	Covered
Medication/Methadone Maintenance	Covered	Covered
Non-Emergency Medical Transportation	“Wrap-Around Service”	Not Covered
Non-Participating Provider	Covered*	Covered*
Observation	Covered	Covered
Obstetrical/ Maternity Care	Covered*	Covered*
Organ Transplant Evaluation	Covered	Covered
Organ Transplant	Covered*	Covered*
Orthotics and Prosthetics (over \$300)	Covered	Covered
Orthotics and Prosthetics (over \$300)	Covered*	Covered*

Benefits	Medicaid	DHCP
Outpatient Surgery: Amniocentesis, Non-Coronary Angiogram, Biopsy, Catheter Insertion, Hardware Removal, Paracentesis, Thoracentesis, Endoscopy (colposcopy, colonoscopy, cystoscopy, EGD, ERCP, laryngoscopy)	Covered	Covered
Outpatient Surgery (any procedure not listed above)	Covered*	Covered*
Pain Management Services	Covered*	Covered*
Pap Smears and Pelvic Exams	Covered	Covered
Podiatry Care	Covered (Routine Foot Care for Diabetes and Vascular Disease)	Covered (Routine Foot Care for Diabetes and Vascular Disease)
Prescription Drugs	“Wrap-Around Service”	“Wrap-Around Service”
Primary Care Provider	Covered	Covered
Private Duty Nursing	Covered*	Covered* (Up to 28 Hours)
Radiation Therapy	Covered*	Covered*
Rehabilitation (inpatient)	Covered*	Covered*
Rehabilitation (outpatient occupational, physical and speech therapies)	Covered*	Covered*
Skilled Nursing Facility Care	Covered*	Covered*
Sleep Apnea Studies	Covered*	Covered*
Specialty Provider Services	Covered	Covered
Tobacco Cessation Counseling	Covered	Covered
Vision (eyeglasses and contact lenses)	Children (Under 21): Annually Adults (Over 21): Every 2 Years	Children (Under 21): Annually Adults (Over 21): Every 2 Years
<p>* Prior authorization required.</p> <p>** Conversion ratio: (all conversion days must be prior-authorized)</p> <ul style="list-style-type: none"> • 1 inpatient day can be converted to 2 residential days or 3 outpatient units. • 20 outpatient units must be used before converting inpatient days to outpatient units. • Any portion of the 30 inpatient days may be converted to outpatient units. • Residential days and outpatient units cannot be converted. 		

10: Claims Policies and Procedures

10.1 Code Sets/Claim Forms

Claims must be submitted to Unison using HIPAA-compliant CPT-4 or HCPCS codes. Hospitals should bill on a UB-04. Other providers, including ancillary providers, should bill using the CMS 1500 (08-05 version), either electronically or via paper. All paper claims must be billed on red and white claim forms; black and white claim forms will not be accepted. Unison requires providers to use a National Provider Identifier (NPI) when submitting claims and EDI transactions. The member ID number, listed on the member's ID card, must be submitted with all claims to Unison for payment.

10.2 Time Frame for Clean Claims Submission

Please allow 30 days for the processing of clean claims. A clean claim is a claim for payment of a healthcare service which has no defect or impropriety, such as a lack of required documentation or a particular circumstance requiring special treatment that prevents the timely adjudication of the claim, and is in compliance with applicable law.

10.3 Claim Status

Providers can check claim status online at www.unisonhealthplan.com. Once you have selected Delaware and the Unison plan, click the *For Providers* tab located at the top of the page and select *Account Information* on the left-hand side to check the status of your claims.

10.4 Billing Unison Members for Services

Payment by Unison is considered payment in full. Unison's participating providers may not seek compensation from a member unless:

- The member is informed in advance that a proposed service is not a covered benefit; and
- The member accepts financial responsibility in a signed document that includes:
 - The services provided;
 - The cost of non-covered services;
 - Notification that Unison will not pay or be liable for the listed services; and
 - Notification that the member will be financially liable for listed services.

You may need to submit copies of these documents to Unison if the member contests receipt of a bill.

10.5 Electronic Claims (EDI)

10.5.1 Why Submit Electronically?

Unison prefers and encourages providers to take advantage of electronic claims processing capabilities. Submitting claims electronically offers the following benefits:

- Faster claims submission
- Expedited payment
- Detailed submission reports
- Increased claims accuracy
- Reduced paperwork
- Time and cost savings

10.5.2 How to Submit Electronically?

If you currently submit claims electronically to other insurance carriers, please contact your software vendor for further instructions. Please notify your vendor that Unison’s payor ID number is 25175. When submitting claims to Unison, it is particularly important that your NPI number and the member’s Unison ID number are present and accurate for each claim. If you are not presently submitting claims electronically, please contact your Provider Relations representative at 800.600.9007 or visit our website at www.unisonhealthplan.com for further information.

All claims submitted using the HIPAA-compliant EDI837 version 4010 format will be accepted for electronic submission. Encounter data must also be submitted using one of these form types. There are a few types of claims and attachments which cannot be submitted electronically to Unison, such as Medicaid attachments and claims for non-payable codes that were negotiated for payment.

10.5.3 Received Dates

The received date of the claim will be dependent upon when the claim is received by Unison. Any claim submitted and received by 7 a.m. on Monday through Friday will have a received date of that business day. Claims received after 7 a.m. will have a received date of the following business day.

10.5.4 Required Fields

Along with the standard fields required, the following must be completed for a claim to be accepted by Unison for processing:

Field Description	CMS 1500 Form (as of 5-23-08)	UB-04 Form
NPI Number	Box 24J*	Box 56
Member ID Number	Box 1a	Box 60
Type of Service Code	N/A	N/A
Date of Service	Box 24A	Box 6 & 45**
DRG Number	N/A	Box 7
Place of Service	Box 24B	N/A

* For PCP claims submitted on the CMS 1500, the physician's individual NPI number is required.

** Date of service must be listed in Box 6 on the UB-04. For outpatient claims, the date of service must also be listed on each line in Box 45 on the UB-04.

10.5.5 Electronic Funds Transfer

Electronic Funds Transfer (EFT) is a method of transferring funds from one bank account to another that eliminates the need for paper checks. EFT transactions are more efficient and more secure than payment by paper checks. To be eligible, participating providers must opt to receive 835 (ERA). New and existing providers can begin receiving EFT payments by submitting the EFT Form at www.unisonhealthplan.com to Provider Administration. EFT transfers should begin within two weeks of receipt of the form.

10.6 Paper Claims

Providers that do not yet have the ability to submit electronic claims should submit their claims in the traditional paper format. If you are mailing claims to Unison, please address the envelope to the correct plan for which the claim is being submitted. If you do not list the plan name, your claim may take longer



to process. **Please note:** to submit a claim for an EPSDT, you should submit a CMS 1500 or UB-04 with a check mark placed in the box labeled 24b.

Medical Claims (i.e. PCP, Specialist, Hospital, Ancillary, UB-04, CMS 1500)
P.O. Box 1147
Monroeville, PA 15146-5138

10.6.1 Payment

All Unison providers are reimbursed at a fee-for-service rate based on Delaware's Medicaid fee schedule. Reimbursement of services is contingent upon proper authorization and member eligibility. Please be sure to submit every claim with a complete and accurate NPI number. Confirmation of eligibility through Provider Services or our automated IVR or website does not guarantee payment. Information about eligibility is only good on the date of query, as the details may change.

10.6.2 Claims

All encounters and services provided to members must be submitted on a CMS 1500 or UB-04, either via paper or electronically, as appropriate. All paper claims must be billed on red and white claim forms; black and white claim forms will not be accepted. The submission must include HIPAA-compliant codes and valid diagnosis codes. Depending on the service(s), the provider may possess an authorization number, obtained from UM respective to the service. In cases where prior authorization is required, the authorization number should be indicated on the claim in the prior authorization field.

To ensure timely filings, new claims for all plans must be submitted within 90 days from the date of service. If Unison is not the primary payor, the provider has 180 days from the date of service to submit a claim. Unison will forward a remittance advice and reimbursement within 30 days from receipt of a claim. However, reimbursement is contingent upon proper authorization and member eligibility.

10.7 Denial of a Claim

10.7.1 Denied Claims

Services are to be provided in accordance with Unison's policies and the respective provider agreement. Reimbursement is likely to be denied for services determined not to be medically necessary or services that have not been properly authorized. Providers will receive a remittance advice for all claims submitted to Unison. If a claim is denied, a reason for the denial will be included on the remittance advice.

10.7.2 Claim Reconsideration

Providers who disagree with Unison's reimbursement determination may contact Unison within 45 days of Unison's remittance advice. Providers may either contact Provider Services or submit a written request, including a letter detailing the reconsideration request, a copy of Unison's remittance advice and any other necessary supporting information to the following address. On the envelope, include the appropriate health plan name for which you are submitting the claim reconsideration request.

Delaware Correspondence
Unison Health Plan of Delaware
P.O. Box 1147
Monroeville, PA 15146-5138



Unison provides notification of the decision on a future remittance advice within 30 days of receipt of the request. Unison will accept subsequent reconsideration requests for the same claim if there is additional supporting documentation that has not yet been submitted. Providers still disputing the reimbursement determination after submitting all supporting information may file an appeal.

11: Special Claims Procedures

11.1 Billing Multiple Procedures

When billing for two or more surgical procedures (provider only) for the same date of service, reimbursement will be per Delaware Medicaid guidelines.

11.2 Assistant Surgeon

Assistant surgeon services are reimbursed based on Delaware Medicaid guidelines if, and only if, an assistant surgeon is required according to the facility bylaws where the procedure is being performed.

11.3 Newborns

During a member's pregnancy, a Healthy First Steps representative aids the member in the enrollment and PCP selection process for the newborn. Newborns are enrolled with the mother's Medical Assistance health plan as of the date of birth. Coverage will exist for at least the first thirty calendar days of life. Reimbursement for newborn services and continuance of coverage with the mother's Medical Assistance health plan is contingent upon notice of delivery to the Department of Health and Social Services and eligibility. Providers may bill newborn services under the mother's ID number until the baby is assigned an ID number.

11.4 Family Planning Provider Claims and Billing

Unison members may self-refer for family planning services, including contraceptive care and urine pregnancy tests. There is no limit to the number of family planning visits a Unison member may have in a calendar year. Reimbursement of family planning services is contingent upon member eligibility. Family planning services for Unison members are reimbursed on a fee-for-service rate based on the appropriate fee schedule. Claim submissions must be submitted on a CMS 1500 or UB-04, either via paper or electronically, and must include HIPAA-compliant codes and valid diagnosis codes. Unison must receive a properly completed claim within 90 days from the date of service.

11.5 Gynecology Claims and Billing

Members may self-refer for gynecological care by a participating gynecological provider. Reimbursement for gynecological care is contingent upon member eligibility. Gynecological services for Unison members are reimbursed on a fee-for-service rate based on the appropriate fee schedule. Claim submissions must be submitted on a CMS 1500 or UB-04, either via paper or electronically, and must include HIPAA-compliant codes and valid diagnosis codes. Unison must receive a properly completed claim within 90 days from the date of service.

11.6 Obstetrics Claims and Billing

Members may self-refer to a Unison-participating OB/GYN for pregnancy care. The treating OB/GYN must contact UM to schedule the delivery and inpatient stay authorization. Reimbursement for obstetric services is contingent upon member eligibility. Obstetric services are reimbursed on a fee-for-service rate based on the appropriate fee schedule. A copy of the Prenatal Risk Assessment Form must be faxed or sent to UM within 15 days from the initial assessment.

Regardless of the pregnancy risk status, OB/GYN providers must submit itemized obstetric procedures on

a CMS 1500 or UB-04, either via paper or electronically, and must include HIPAA-compliant codes and valid diagnosis codes. Unison must receive a properly completed claim within 90 days from service date.

The OB/GYN may refer any pregnant member for additional services, including the Smart Start program, after obtaining a pregnancy authorization upon completion of the prenatal assessment. UM will authorize and coordinate the following prenatal services with a Unison-participating provider:

. Psychosocial counseling

- Nutrition assessment by a registered dietitian
- Smoking (tobacco) cessation counseling
- Substance abuse assessment and counseling
- Genetic risk assessment and counseling (two units per pregnancy)
- Prenatal parenting (one program per pregnancy)
- Prenatal exercise (one program per pregnancy)
- Skilled nurse visits.

11.7 Basic (Low- or No-Risk) Pregnancies

Unison will cover prenatal services, delivery and postpartum care in accordance with the state prenatal guidelines. Additional postpartum home care must be coordinated through UM. The provider must contact UM to schedule the delivery and inpatient stay authorization upon completion of the prenatal assessment. The authorization request will be evaluated to identify the risk status of the pregnancy. The pregnancy will be certified as basic if there is low or no risk of an adverse pregnancy.

Providers must submit itemized obstetric procedures on a CMS 1500 or UB-04, either via paper or electronically, and must include HIPAA-compliant codes and valid diagnosis codes. Unison must receive a properly completed claim within 90 days from the date of service. A copy of the Prenatal Risk Assessment Form must be faxed or sent to UM within 15 days from the initial assessment. Unison requests that the *Healthy Beginnings Plus* intake package is completed and placed in the member's file; however, copies of the forms do not need to be sent to Unison.

11.8 High-Risk Pregnancies

Upon completion of the prenatal assessment, the provider must contact UM to schedule the delivery and inpatient stay authorization for care management and pregnancy tracking purposes. The Prenatal Risk Assessment Form will be evaluated to identify risk status of the pregnancy. The pregnancy will be certified as high-risk if there are indicators of an adverse pregnancy. Unison will cover prenatal services, delivery and postpartum care in accordance with the state prenatal guidelines. Additional postpartum home care must be coordinated through UM.

A Unison member must meet Unison's high-risk criteria in order for services to be reimbursed at the high-risk rate. A copy of the Prenatal Risk Assessment Form must be faxed or sent to UM within 15 days from the initial assessment. Providers must submit itemized obstetric procedures on a CMS 1500 or UB-04, either via paper or electronically, and must include HIPAA-compliant codes and valid diagnosis codes. Unison must receive a properly completed claim within 90 days from the date of service.

11.9 Professional Component Billing

When processing claims for the professional component, the hospital claim is considered the lead claim. The claim for the professional component of the services, which are provided in a hospital setting, is

processed in accordance with the information provided on the hospital claim.

11.10 Hospital Billing Procedures

Hospital claims are submitted to Unison via a UB-04. To assure that claims are processed for the correct member, the member's Unison Medicaid ID number must be used on all claims. All participating hospitals have numerous provider numbers. Hospitals providing OB/GYN and PCP services will continue to have separate provider numbers for these services. Please be sure to submit every claim with a complete and accurate provider number. Please contact your hospital's Provider Relations representative at 800.600.9007 with any questions about your provider ID numbers.

11.11 Anesthesia Billing Procedures

Anesthesia billing should use appropriate ASA (American Society of Anesthesiologists) codes:

- Minutes should be billed in box 24G of the CMS- 1500.
- Start and Stop time should be billed in box 19 of the CMS- 1500.
- Unison will calculate time and base units.
- Modifiers AA, QK, QX, QY and QZ must be reported as appropriate. According to current coding guidelines, modifiers that affect pricing are QK and QX. When appended to a procedure, it will cause a reduction in reimbursement.

11.12 Professional Services Rendered by a Behavioral Health Provider

Behavioral health providers should use the following modifiers when submitting a claim:

- Psychologist - HP
- Master's Level - HO
- MDs do not need to bill a modifier.

11.13 Coordination of Benefits

As a Medical Assistance managed care choice, Unison coverage is the 'payor of last resort' when a primary insurer is present. A Unison member may have primary insurance coverage through Medicare or a commercial insurance carrier.

The provider must first submit the claim to the primary insurance or third party carrier. Upon receipt of payment from the primary insurer, the provider must submit a copy of the Explanation of Benefits to Unison. This also includes the difference between the amount received from the third party payor and the contracted amount. Unison will then process the claim and, if appropriate, issue payment up to the health plan's contracted fee schedule. (i.e., benefit less benefit provision). Please note that before providers may bill Unison for copayments, the treating provider must verify the member's Unison Medicaid eligibility on the date of service. Unison-participating providers may not charge a member unless the following circumstances exist:

- The provider may bill the member if the provider is not a participating provider of Delaware Medicaid, Unison or the private carrier, or;
- If the recipient has Medicare and is advised, by the provider, prior to receiving a non-covered service that the member is responsible for the copay then the provider can bill the recipient.



The provider must adhere to Unison's prior authorization guidelines, except in situations in which Medicare is primary. If the service is not a covered benefit under Medicare, prior authorization by Unison is required.

11.14 Subrogation Policy

Unison is responsible for the medical care of a member who is injured or becomes ill as a result of an act by a third party. Unison is required to notify the DMMA. Unison and the provider must reciprocate notification of involvement in such cases. Treating providers should notify UM as soon as possible.

12: Prior Authorization

12.1 Services that Require Prior Authorization

Unison includes a broad range of benefits to meet a member's health care needs. The prior authorization process evaluates the appropriateness, the intensity and proposed location of a requested service. UM will accept prior authorization requests from either the PCP or consulting provider.

12.2 Responsibility for Requesting Prior Authorization

The PCP or specialist can telephone or fax a request to Unison for the prior authorization of services. UM provides on-call staff availability 24/7 for prior authorization purposes. Medical directors and UM representatives use nationally recognized criteria (InterQual) or plan-specific criteria for the review of service requests. All decisions are based upon medical necessity. Requesting providers must have the following information available at the time of the prior authorization request:

- Member name, DOB and recipient identification number
- Provider name and ID number
- Caller name, phone/fax number
- Date(s) service will be performed
- Name and ID number of facility where services will be performed
- Diagnosis by ICD-9 code
- Procedure by CPT or HCPCS code
- Supporting clinical information and treatment plan.

If the criteria are not met, the case is presented to a Unison medical director. Under these circumstances, the medical director may discuss the case with the member's treating provider. The medical director may also consult the EQIC and other network providers. The treating provider may contact the medical director to discuss the case. For Unison members, peer review is always used in the case of payment denial for services provided to a member under age 21.

Any change or reduction to the original request is considered a denial and a denial letter will be issued to the provider and the member. The requesting provider or appropriate party will always be supplied with the rationale of the denial determination. A denial may be based on one or more of the following:

- Lack of proper notification (procedural denial)
- Service is not a covered benefit or not medically necessary
- Place of service not medically necessary
- Delay in treatment not attributable to the patient's condition.

Providers may request a copy of the clinical criteria and may appeal medical and procedural denials according to the Unison appeal process found in the Member Grievance and Appeal Procedures section of this manual. To request these criteria, please write to:

Utilization Management
Unison Health Plan
1001 Brinton Road
Pittsburgh, PA 15221

12.3 Medical Necessity

Medical necessity is defined as the essential need for medical care or services (all covered state Medicaid plan services, subject to age and eligibility restrictions and EPSDT requirements) which, when prescribed by the beneficiary's primary physician care manager and delivered by or through authorized and qualified providers, **will:**

- Be directly related to the diagnosed medical condition or the effects of the condition of the beneficiary (the physical or mental functional deficits that characterize the beneficiary's condition) and be provided to the beneficiary only;
- Be appropriate and effective to the comprehensive profile (e.g. needs, aptitudes, abilities and environment) of the beneficiary and the beneficiary's family;
- Be primarily directed to treat the diagnosed medical condition or the effects of the condition of the beneficiary, in all settings for normal activities of daily living, but will not be solely for the convenience of the beneficiary, the beneficiary's family or the beneficiary's provider;
- Be timely, considering the nature and current state of the beneficiary's diagnosed condition and its effects, and be expected to achieve the intended outcomes in a reasonable time;
- Be the least costly, appropriate, available health service alternative and will represent an effective and appropriate use of program funds;
- Be the most appropriate care or service that can be safely and effectively provided to the beneficiary and will not duplicate other services provided to the beneficiary;
- Be sufficient in amount, scope and duration to reasonably achieve its purpose;
- Be recognized as either the treatment of choice (i.e. prevailing community or statewide standard), common medical practice by the provider's peer group or the functional equivalent of other care and services that are commonly provided; and
- Be rendered in response to a life threatening condition or pain or to treat an injury, illness or other diagnosed condition or to treat the effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation, including the loss of physical or mental functionality or developmental delay,

and will be reasonably determined to:

- Diagnose, cure, correct or ameliorate defects physical and mental illnesses, diagnosed conditions or the effects of such conditions; **or**
- Prevent the worsening of conditions or effects of conditions that endanger life or cause pain, result in illness or infirmity or have caused or threaten to cause a physical or mental dysfunction, impairment, disability or developmental delay; **or**
- Effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an institutional setting or other Medicaid program; **or**
- Restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury or other diagnosed condition or the effects of the illness, injury or condition; **or**
- Provide assistance in gaining access to needed medical, social, educational and other services required to diagnose, treat or support a diagnosed condition or the effects of the condition;

in order that

- the beneficiary might attain or retain independence, self-care, dignity, self-determination, personal safety and integration into all natural family, community and facility environments and activities.

12.4 New Technology

If requests are received for services involving new technologies, the medical directors will review all available sources of information prior to making a determination in accordance with our policy. This process includes a review of available published literature, consultation with services that evaluate new technologies (including medical procedures, behavioral health procedures, pharmaceuticals and devices) and a consultation with experts, as needed, before rendering a decision on coverage of the requested service. Unison evaluates new technology that is not covered on a case-by-case basis. Providers are encouraged to contact UM or a medical director for prior authorization of these services.

12.5 Durable Medical Equipment

Providers must obtain a prior authorization from Unison for DME items with a billable charge greater than \$300. A DME Prior Authorization Form may be faxed to UM at 877.877.8391. Providers for all Unison products must also receive a prior authorization from UM for all DME rentals. The rental will be approved for up to three months or for the actual purchase price of the equipment, whichever is the lesser amount. The treating provider should contact Unison for DME authorizations.

12.6 Unison Prior Authorization Guide

Please refer to the list below for the Unison Medicaid and DHCP services requiring prior authorization.

- Ambulatory surgical procedures, except amniocentesis, angiograms without cardiac catheterization, endoscopic surgical procedures not including arthroscopy and laparoscopy, ERCP, fracture care, surgical procedures in provider's office.
- Admissions to a hospital or any other facility (emergency admissions require authorization within 48 hours of admission, or the next business day).
- ASH elective procedures (i.e. abortion, sterilization, hysterectomy)
- Behavioral health (inpatient, residential treatment facility, partial hospitalization)
- Bone mass measurement (bone density), except DEXA scans
- Diabetic supplies and equipment (over \$300)
- Durable medical equipment (purchases over \$300 and all rentals)
- Enteral/parenteral therapy
- Genetic testing
- Home health care
- Hospice care
- Non-participating providers
- Non-emergency ambulance services
- Obstetrical/maternity care
- Organ transplant
- Orthotics and prosthetics (over \$300)
- Outpatient services (including arthroscopy, cardiac catheterization, CT scans, laparoscopy, MRIs and MRAs, PET scans, SPECT, Sleep apnea studies including at home studies)
- Pain management services
- Pharmaceuticals (including cancer agents) billed in a specialty provider's office or approved outpatient setting (over \$250)
- Podiatry services, except routine services with diagnosis of diabetes or peripheral vascular disease
- Private duty nursing
- Radiation therapy
- Rehabilitation (inpatient; outpatient occupational, physical and speech therapies)

12.7 Medical Director/UM Reviewer Availability

A Unison medical director is available to discuss any UM process or denial decisions. You can contact the medical director by calling at 800.366.7304.

12.8 Affirmative Statement about Incentives

Unison affirms that UM decision-making is based only on the appropriateness of care and services and the existence of coverage. Unison does not specifically reward providers or other individuals for issuing denials of coverage or care. Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

12.9 Access to Unison Staff Members

The UM staff is available at least eight hours a day, during normal business hours, for inbound calls regarding UM issues. The staff can receive inbound communication regarding UM issues after normal business hours. Staff members can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon. Staff members identify themselves by name, title and organization name when making calls about UM issues. If you have any questions about the UM process, please call 800.366.7304.

13: Preventive Health and Clinical Guidelines

13.1 Preventive and Clinical Health Care Standards

Unison's Corporate QI/UM Committee develops, reviews and revises preventive care and clinical practice guidelines (CPGs) relevant to the populations served by Unison plans and in keeping with contractual, regulatory and external accreditation programs. Guidelines are reviewed, revised and approved every two years and as necessary when national guidelines change. Documentation of the review is maintained either at the corporate office or at the health plan, depending upon who performs the review. Preventive health care guidelines and CPGs are available at www.unisonhealthplan.com.

Unison's goal is to partner with providers to ensure that members receive preventive care. Unison endorses and monitors preventive health standards recommended by recognized medical and professional organizations. Unison monitors the provision of these services and the adherence to our guidelines through chart reviews and analysis of encounter data.

13.2 Preventive Care and Screening Tests

Preventative care and screening tests include: bone mass measurements, colorectal screenings, immunizations, mammography screenings, Pap smears, pelvic exams, clinical breast exams, prostate cancer screening exams, cardiovascular screening blood tests and routine physical exams, and others as noted in the current preventive health guidelines.

13.3 Mammogram Screenings

Unison supports access to and utilization of mammography through the education of members and by encouraging self-referral to participating providers for mammogram screenings.

13.4 EPSDT Information for Unison Providers

Unison's Pediatric Services program includes EPSDT screenings for children up to age 21. It is essential that children enrolled in Unison Medicaid receive screening exams at the appropriate ages. The PCP member roster identifies those members who are due for an EPSDT screen in the upcoming month. Unison will work with the PCP to notify members due for an EPSDT screening.

13.4.1 Scheduling EPSDT Appointments

Unison closely monitors EPSDT compliance. The PCP is responsible for providing EPSDT outreach and follow-up care. Appointments for EPSDT screenings should be made within two weeks after the initial request. The PCP must notify Unison when a member cancels or does not attend an EPSDT appointment within 30 days from the scheduled appointment. Unison has developed a form for this purpose located at www.unisonhealthplan.com. Member Services will help the PCP contact members who are not compliant with the EPSDT scheduling requirements. The form may be faxed to 412.457.1377 or mailed to:

EPSDT Department
Unison Health Plan
1001 Brinton Road
Pittsburgh, PA 15221

13.4.2 Reporting EPSDT Encounters

All EPSDT screening services should be reported to Unison on a HIPAA-compliant claim form. Please note the following concerning EPSDT encounters:

- Diagnosis code V20.2 must be noted as the primary diagnosis.
- Appropriate evaluation and management codes must be included.
- Appropriate charges must be listed for each line item.
- You have 90 days to submit completed EPSDT encounters.

For providers electing to submit on a UB-04 or 837I, please note that both an appropriate procedure code and revenue code must be provided.

13.4.3 Childhood Immunizations

The Unison EPSDT guidelines include immunizations for children through the age of 18 in compliance with the Vaccines for Children (VFC) program. The State of Delaware participates in VFC to provide vaccines to all public and private health care providers who agree to participate in the program. The PCP should distribute biologicals obtained through VFC to Unison members requiring immunizations. The State of Delaware operates an immunization registry and Unison strongly encourages providers to work with the registry.

The member's immunization encounter must be documented on a CMS-1500 or UB-04. The PCP will not be reimbursed for biologicals obtained through VFC.

13.4.4 Lead Screening Guidelines

The Unison EPSDT guidelines include blood lead level screenings for children who are between the ages of six and 72 months. A Lead Screening Questionnaire should be completed at the time of each routine office visit for children of this age group. The questionnaire assesses the potential for high-dose lead exposure. The results of the Lead Screening Questionnaire will dictate the frequency of subsequent lead screenings. Children considered to have a low risk must have an initial blood lead test performed between the ages of 9 and 12 months and a second blood test at 24 months. Unison has contracted with LabCorp, Quest Diagnostics and participating hospital laboratories for blood testing.

13.4.5 Pediatric Expanded Services

Children may be eligible for additional services under the EPSDT program. Requests for expanded services must be submitted in writing to UM.

14: Quality Improvement Program

14.1 Overview

The QI program is designed to continually evaluate, monitor and improve the quality of care and services that Unison provides. The program identifies and recommends ways to improve health care and related services delivered to Unison members through the use of continuous QI concepts and methods, such as:

- Evaluating clinical and administrative aspects of care and services provided to members to determine areas for improvement,
- Recommending corrective plans of action to improve the quality of care and service,
- Implementing the plans of action, and
- Measuring the effectiveness of interventions to improve the quality of care, customer service and the health status for the members it serves.

14.2 Provider Participation in Quality Management

Unison has a Quality Improvement/Utilization Management (QI/UM) Committee through which participating providers give Unison advice and expert counsel in medical policy, quality management, and QI. A medical director chairs the QI/UM Committee, which meets on a regular basis and has oversight responsibility for issues affecting health services delivery. The QI/UM Committee is composed of participating providers and Unison management staff and reports its recommendations and actions to the Unison board of directors.

14.3 Quality Goals

To continually enact comprehensive and effective change and improvement throughout Unison's health plan operations, the QI program has established the following objectives:

- To evaluate procedures designed to ensure that members and providers are treated with respect and that privileged information is held in confidence
- To coordinate QI activities in accordance with applicable plan/product requirements
- To ensure that the providers in the Unison network meet or exceed the minimal standards of availability, accessibility and quality
- To ensure that the range of expertise of the providers in the Unison network is sufficient to meet the needs of Unison members
- To monitor Unison's and network-participating providers' clinical and administrative performance and to identify areas where improvement is required
- To evaluate the health status of Unison members and identify specific health problems that require improvements in health promotion, disease prevention and health care services
- To evaluate the effectiveness of interventions designed to improve Unison and network-participating provider performance
- To identify the most common chronic illnesses occurring in Unison members and assist Unison team members in evaluating the impact of care management and disease management programs designed to improve the quality of their care
- To assist Unison team members in educating providers to improve their performance, when required
- To evaluate the satisfaction of Unison members and providers with services and recommend appropriate ways to improve services when warranted
- To monitor, evaluate and intervene on complaints about administrative processes or access to Unison

through Member Services, Provider Relations, UM and the Pharmacy to ensure that the highest level of service to all customers is maintained

- To implement educational programs for personnel, in collaboration with Unison team members, to improve the quality of company operations
- To promote a supportive milieu for members and providers that addresses improving patient safety through member education, pharmaceutical management and physician and provider education.

14.4 Monitoring and Improving Quality of Care

The QI program tracks certain indicators of plan performance to assess the quality, adequacy and appropriateness of health care resources used. Performance indicators are based upon:

- The accessibility of providers, which is evaluated by analysis of complaint data and on-site and investigative reviews
- Provider availability, which is monitored by GEO access reports and subsequent analysis of standards
- Member and provider satisfaction with the plan services and UM process, which is monitored by CAHPS[®] and provider satisfaction survey results and complaints
- Credentialing and re-credentialing standards, which are monitored by adherence to standards and time frames
- Provider adherence to published clinical practice guidelines, which is measured by annual guideline measures
- Preventive health services, which are measured by HEDIS measures and chart audits
- Continuity and coordination of care processes, which are evaluated by survey and chart audits
- Access to Member Services team members, which are evaluated by telephone statistics
- Quality of care problems evaluated by member complaints and sentinel events
- Patient safety, which is monitored by drug interactions/medication safety, site reviews, adverse sentinel events, hospital surveys and nursing home care
- Disease management program process and outcome measures, which are evaluated through Health Management analysis
- Health promotion services for children and adults, which are measured by HEDIS measures and chart audits.

14.5 Development of Clinical Practice Guidelines

Unison develops and distributes clinical practice guidelines associated with acute and chronic conditions prevalent in the membership population in an effort to assist providers and members with health care decisions. Unison's QI team, in conjunction with the QI/UM Committee updates these guidelines based on medical evidence provided by our Medical Management team or in nationally recognized clinical publications. The guidelines are available on the Unison website at www.unisonhealthplan.com.

14.6 Ongoing Evaluation Activities

QI activities that support the goals and objectives of the QI program are coordinated on an annual basis. The program cycle is based on the calendar year, January through December. The QI/UM work plan is the document that identifies the yearly activities that support the QI program. Included in this work plan are the objectives for the year, the program scope and clinical and service quality activities. A time frame for implementation will be noted for each activity along with the person or department responsible for that activity and a highlight of when interval analysis takes place. The annual QI program evaluation includes a summary of QI activities, the impact of the QI program and the need for revision.

Throughout the year, potential risk management cases and quality of care problems (including critical incidents and sentinel events) will be evaluated through a formal program which will identify those cases that require investigation and follow-up and establish the data collection mechanism for trending purposes. This process will be conducted as part of Unison's peer review activities. Each potential risk management or potential quality of care problem is reported to Quality Improvement, and is investigated to determine the assignment of a quality concern level and initiation of an action plan. Quality Improvement will refer all necessary issues to the medical director for review. Information used for tracking and trending purposes includes:

- Date of incident or identification
- Member identification number
- Involved participating provider, if other than PCP
- Facility (site) where the problem occurred
- Problem description
- Quality concern level
- Action steps
- PCP name
- Outcome/follow-up.

At least quarterly, Quality Improvement will prepare a summary of tracking activities for review by the QI Committee. The QI/UM Committee acts as a forum in trending quality of care issues and monitoring for system-wide problems. Focused studies/audits or multi-disciplinary teams may be recommended for pursuing QI initiatives for system-wide problems.

14.7 Monitoring Member and Provider Satisfaction

Unison monitors member satisfaction to ensure that all member interactions are effective and to identify opportunities to improve the full range of our operational processes, including:

- Availability and accessibility of health providers and services
- UM procedures
- Quality and service provided in practice settings
- Quality of Member Services.

Unison analyzes member satisfaction data from all sources, including member satisfaction survey data, member complaints and grievances, and provides for interval analysis and an annual aggregate report. The report includes the assessment of member satisfaction data and the monitoring methodology, a quantitative and qualitative analysis, year-to-year trending, comparisons to goals and benchmarks, barrier analysis, opportunities for improvement and evaluation of the effectiveness of past interventions.

Unison will employ the Consumer Assessment of Health Plans Survey (CAHPS) data, member complaints and member grievances. The CAHPS survey provides an integrated set of carefully tested and standardized questions to collect and report meaningful and reliable information about the experiences of the members. In addition, Unison collects and reports all member complaints, which are categorized by reason when entered into the information system and reported by number and complaints per 1,000 members. Complaints are reported quarterly to the Operations Committee. All member grievances are logged upon receipt by the Grievance and Appeals staff and categorized by reason. Grievances are reported quarterly to the QI/UM Committee.

Unison evaluates provider satisfaction using an annual satisfaction survey. The surveys, which are used for primary care providers (PCPs), high-volume specialty care providers, ancillary providers, hospitals, dental providers and behavioral health providers are managed by Quality Improvement. These providers receive surveys in the mail. High-volume specialists are determined from claims analysis based on volume and include OB/GYN providers. The following categories of ancillary providers also receive surveys: DME, home health, hospice, infusion, medical supplies and orthotics/prosthetics.

14.8 Peer Review Procedures

The Unison medical director will always contact a provider if there is a question about complaints, credentialing, the quality of care, sentinel events or services delivered. If the medical director and individual provider or practice can not resolve the issues adequately and pursuant to state and federal regulations, the issues will then be sent to the appropriate Unison QI/UM Committee.

14.9 Additional Program Information

To obtain additional information on the QI program, including a description and report of activities and process toward its goals, please write to:

Quality Improvement
Unison Health Plan
1001 Brinton Road
Pittsburgh, PA 15221

15: Care Management Services

15.1 A Resource to Address Complicated Medical and Social Needs

Unison strongly believes in the use of care management services to promote comprehensive coordinated care. Our care management program serves as an individualized service delivery based on comprehensive assessment tools that are used to develop a care plan. The care plan is developed in collaboration with the member, family (if applicable) and the treating provider. The goal is to empower members and involve them in all aspects of planning and service arrangements.

The Unison philosophy expands on this premise, as we believe that psychosocial issues, especially in the Medicaid population, directly impact members' ability to manage their diseases or conditions. To this end, our care management team employs a multidisciplinary approach in which the clinical care management (registered nurse) activities are complimented by social work-based care managers through our Special Needs Unit (SNU).

15.2 Provider Involvement

Providers (physicians and advanced practice nurses) can be actively involved in our care management programs in several ways. The plan recognizes the importance of including not only the treating provider on a member-by-member basis but also using the expertise of practicing providers in the ongoing refinement of the program. The various processes for provider involvement are described below:

- Each treating provider is notified in writing and by telephone at the time of a patient's enrollment in the care management program and is invited at that time to participate in the initial and ongoing development of the care plan. The care manager may contact the primary treating provider in order to design specific interventions in conjunction with the provider's treatment plan. The care manager takes this opportunity to develop a relationship with the treating provider and office staff.
- The care managers contact the treating provider with any serious changes in a member's condition to update and redirect the care plan.
- Providers receive a quarterly roster of their members accompanied by a patient profile or report card (for certain programs) that provides relevant member-specific medical information such as condition monitoring, adherence to treatment plans and identification of co-morbid conditions.
- Annually, providers receive health management program descriptions. These descriptions outline key activities that illustrate program services, including care management services, and identify how the plan works with both the provider and the member.
- Providers are strongly encouraged to refer patients to care management as needed.

Providers can refer their patients for care management by any of the following methods:

- Fax the Health/Care Management Referral Form to 866.839.4066. The form is located on Unison's website at www.unisonhealthplan.com.
- Call Care Management at 877.844.8844 to identify the member, or
- Mail the Health/Care Management Referral Form to:

Care Management
Unison Health Plan
1001 Brinton Road
Pittsburgh, PA 15221

15.3 Health/Care Management Programs

15.3.1 Catastrophic Care Management

Unison's Catastrophic Care Management program identifies and risk-stratifies the medically complex population with consideration to co-morbid conditions and social environment. Activities are designed to address members within the continuum of their diseases, including educational outreach, ongoing-targeted short- and long-term care management and collaboration with the member's provider and other health care team members to effectively educate and develop an optimal treatment plan to help the member manage their conditions. The Catastrophic Care program is divided into the following condition groups:

- Adult Care Management
- Pediatric Care Management
- Neonatal Care Unit (NICU).

15.3.2 Respiratory Health/Care Management

The Respiratory Health/Care Management program focuses on members with moderate to severe asthma or COPD. The program has a strong emphasis on improving the quality of life, patient education and the increased usage of long-term control medications. Each patient is assessed and stratified and the care plan intensity can range from basic educational mailings, for those members who require limited assistance, to comprehensive care plans with frequent outreach to both the patient and treating provider.

15.3.3 Cardiac Care Health/Care Management

The Cardiac Health/Care Management program focuses on health education and improving compliance with the provider's treatment plan. Patients are identified through claims, medication usage, utilization hospital census reports and providers and by the patients themselves. Members identified as having congestive heart failure (CHF), coronary artery disease (CAD) or hypertension are offered inclusion in this program. Care plans are customized to meet members' health educational needs and to support the provider's treatment plan. For example, those patients identified with CHF that demonstrate healthy self-management skills will receive CHF educational mailings. Patients will also receive educational materials for co-morbid conditions such as diabetes and asthma.

15.3.4 Kidney Care Management

The Kidney Care Management program offers patients an intense program with a strong team focus. Members suffering from end-stage renal disease (ESRD) or chronic kidney disease are invited to be a part of this program. These patients will work closely with a registered nurse and social worker on identified medical and social issues. The Unison team members will work closely with the treating provider and dialysis clinic, if indicated, in focusing on the provider treatment plan. Identification of this population of patients comes from claims data, providers and self referrals.

15.3.5 High-Risk Pregnancy Health/Care Management

The High-Risk Pregnancy Health/Care Management program partners with the Healthy First Steps program, which offers a "buddy" system for all pregnant members to encourage prenatal care, and with Delaware's Smart Start program. You may make a referral to Smart Start through Care Management. Members are identified as high-risk primarily through the OB/GYN provider's submission of the OB Needs Assessment Form, which is completed during the first prenatal visit. The assessment form is

designed to clearly identify members that are at risk of pre-term labor or a poor pregnancy outcome.

15.3.6 Diabetes Health/Care Management

The Diabetes Health/Care Management program focuses on education and improved compliance with the provider's treatment plan. Patients are primarily identified through claims and pharmacy activity, but as with all of the programs, members, treating providers and Utilization Management (UM) are also strong referral sources. Member are assessed and stratified and the care plan is customized to meet each member's needs. Members that require limited assistance will receive educational mailings, while members who require a more intense approach will receive a comprehensive care plan that includes frequent outreach to both the member and the treating provider.

15.3.7 Transplant Care Management

The Transplant Care Management program monitors the member from the initial evaluation to one year after transplantation. Activities are designed to address members within the continuum of care and provide ongoing, targeted care management, including collaboration with the member's providers and the facility transplant team. The transplant care managers are assigned as the member enters the transplant evaluation process. The care manager performs the UM activities associated with the transplant evaluation, all inpatient admissions and related outpatient services. The care manager develops a relationship with the patient, family and the hospital transplant team, which allows the care manager to support the patient and family through a very difficult and stressful experience.

15.4 Behavioral Health Care Management (Mental Health and Substance Abuse)

The philosophy for providing optimal treatment for our members is a holistic approach. Therefore, the coordination of care between the member, the member's family, the behavioral health providers, the medical providers and Unison care managers is essential to meet this goal. Unison offers care management for members with complex behavioral health and substance abuse conditions.

Once involved in the behavioral health case management program, members can expect telephonic outreach by one of the behavioral health care management staff on an ongoing basis to answer questions and provide education related to behavioral health/substance abuse needs. Members are primarily identified through utilization of behavioral health and substance abuse services and both internal and external referrals. Members may also self-refer to the Behavioral Health Care Management program.

Members seeking behavioral health treatment will receive care on multiple levels. The following list includes ways our providers can help serve members:

- Establish communication between providers at the facility and provider level to coordinate care.
- Meet behavioral health appointment standards as follows:
 - Life-threatening emergency should be seen immediately,
 - Non-life-threatening emergency within 6 hours,
 - Urgent need within 48 hours,
 - Routine office visit within 7 calendar days.
- Begin the discharge planning process once a member is admitted. The Unison care manager will assist in the provision of in-network options and linkage.
- Follow the Health Plan Employer Data and Information Set (HEDIS) requirement of following up after hospitalization, occurring ideally within seven days of discharge and, at the most, within 30 days of discharge. The goal for Unison BHS is to meet this requirement as this measure assists in continuity of care for the member and decreases the risk of re-admission to an acute setting. Facilities

and providers are to assist in the planning for a follow-up after hospitalization to meet this standard.

- Follow the HEDIS recommended specific appointment follow-up for the prescription of anti-depressant and Attention Deficit/Hyperactivity Disorder (ADHD) medication. The expectations from HEDIS are as follows:
 - > **Antidepressant Medication Management:** Pertains to any member 18 years of age or older. Members who are diagnosed with a new episode of depression and are started on anti-depressants are optimally scheduled with either a mental health provider or a non-mental health provider for three follow-up visits within 12 weeks of the initial prescription. At least one of the three visits must be with the prescribing provider.
 - > **Attention Deficit/Hyperactivity Disorder (ADHD) Medication Management:** Pertains to members between the ages of 6 and 12 years of age. For those started on a new prescription, the expectation is that a prescribing provider will have a follow-up visit with the member within 30 days of the start of medication.

15.4.1 Behavioral Health Utilization Management

The Unison Behavioral Health utilization managers possess either a registered nurse license or they are master's-level licensed clinicians. The Unison care manager will review treatment requests first as a prior authorization and then on a concurrent review basis using InterQual criteria. The following services require review by a Unison care manager (please refer to the benefit chart for limitations):

- Inpatient and partial hospitalization
- Intensive outpatient
- Psychological testing
- Outpatient ECT
- Outpatient detoxification
- Home health services.

Individual outpatient services do not require prior authorization. Unison's behavioral health staff reviews the outpatient services rendered and reserves the right to request a clinical progress review.

15.5 Special Needs Unit (SNU)

The Special Needs Unit will work with you to support members who have a serious and complex condition, disability or other special need issue that complicates the health care that you are trying to provide. The social work-based care management of the SNU provides support and assistance to the clinical care management program. The SNU typically works with the following members:

- Members who have identified the existence of a special need upon enrollment
- Members referred from other Unison departments
- Members who potentially have difficulty accessing the benefits available to them, such as:
 - > Members seeking specialists as PCPs,
 - > Members with complex social or environmental needs,
 - > Members with transportation needs,
 - > Members that over- or under-utilize benefits,
 - > Members at risk of being removed from PCP rosters,
 - > Members with complex health care issues that need assistance with follow-through, making decisions and care coordination, and
 - > Members that demonstrate a pattern of behavior that indicates that additional services (social, behavioral health or community) may be useful.

The SNU is equipped with the multidisciplinary competencies and community linkages that are necessary to work with members possessing both short-term issues and long-term chronic situations. The SNU's goal is to assist the member in preventing or overcoming the factors that may interfere with satisfactory primary care outcomes.

15.5.1 Special Education Services

Unison's Special Needs Unit (SNU) will assist members with special needs who may be eligible for and would benefit from services offered through the public education system. Providers identifying patients who may be candidates for such assistance should contact the SNU. The SNU will identify candidates from education and outreach calls placed to members, contact with providers, information on EPSDT forms and information obtained during routine care management services.

Upon the identification of a member in need of services offered through the public education system, the SNU care manager will educate the member and the member's family about available services. Should the member or family indicate they are not interested in the services, the SNU care manager will offer SNU assistance for the future should they change their mind. Whether or not the member or family accepts the SNU's assistance, the care manager will ask the member or family if they would be interested in receiving a special education information packet, which is designed to educate members and families about special education and provide them phone numbers for educational advocates that are available to help them. Member's requesting SNU assistance in obtaining services from the school system will be asked to sign a release form. The SNU will then assist the member and family in obtaining services from the school system, as appropriate and desired by the member and their family.

15.6 Member Advocates

Unison's member advocates work with members and providers to facilitate the delivery of health care services. Member advocates can help members to access their care and provide training and educational materials to providers to enhance understanding of the values and practices of all of our members' cultures. Member advocates also provide input to Unison on how provider changes will affect member access, quality of care and continuity of care issues, as well as medical record requests. Member advocates can be reached by calling 877.877.8159.

15.7 Member Services Call Center

Our members may have to access urgent/emergency care before our call center is open and after hours. Unison Member Services representatives are available 24/7 to answer member questions. Member Services representatives take advantage of every opportunity to educate members on the role of the PCP, the importance of getting regular check-ups and practicing preventive care to prevent the need for urgent/emergency care.

15.8 24/7 Nurse Line

Members may call Unison's 24/7 nurse advice line to obtain information about their health problems and seek advice. The 24/7 line is not intended to be a triage center, as it provides information of a more general nature.

16: Compliance

Unison operates a compliance program that applies to all the companies in our insurance holding company system. This organization-wide compliance program is administered by the Unison compliance officer. The program is documented in written policies and procedures and a formal compliance plan, which includes an employee code of ethics. Introductory compliance training is provided to all new hires. Refresher compliance training is provided on an annual basis to all members of management and other selected groups as necessary.

The compliance program is publicized through periodic company-wide e-mails, posters in employee common areas and live compliance training. Employees are advised of their obligations and the methods to report compliance issues, including anonymous reporting methods and the disciplinary guidelines used for compliance violations. The compliance officer is available to receive compliance reports or inquiries in person, by telephone, anonymous online reporting, mail or e-mail. The Unison compliance officer reports directly to a member of the Unison board of directors on a regular basis and compiles an annual report of compliance activities for the Unison board of directors.

The compliance officer works in conjunction with all Unison senior management to ensure that Unison and its employees comply with 1) all laws, regulations and agency standards governing the various government-funded managed care programs in which we participate; 2) all contracts to which Unison is a party; and 3) all internal policies. The compliance officer responds to inquiries and investigates compliance reports about Unison's operations.

A Compliance Committee periodically meets to review the activities of the Unison companies and assist the compliance officer with this significant function. The committee meets formally at least annually and more frequently as needed through the year. The committee reviews past and future training efforts as well as a summary of the annual compliance report. The committee also reviews and approves all Compliance policies and procedures and provides input and suggestions on compliance issues.

16.1 Fraud and Abuse Controls

Unison employs a multi-faceted approach to identify, detect and prevent fraud and abuse in the public sector health plans that are our market focus. These actions include, but are not limited to claims edits, post-processing review of claims, provider profiling and credentialing, quality control and UM.

All network providers undergo a government program sanctions review as part of the credentialing process. The standard network participation agreement requires that providers immediately notify Unison Health Plan if they are terminated, suspended or otherwise excluded from the Medicare, any Medicaid or any other public sector health plan. Additionally, if we discover that a participating provider has been so excluded, Unison will immediately terminate the provider's participation agreement. We also act to detect fraud and abuse through provider profiling, claims adjudication and audits and medical records review. Providers are reminded that, because Unison focuses solely on the public sector health plan market, payments from Unison are derived from government funds and that civil or criminal penalties may apply for fraud, program abuse or other misrepresentations.

Similar to many other fraud and abuse detection and prevention mechanisms, Unison regularly conducts audits to ensure compliance. Audits may be conducted on a pre-payment basis as well as retrospectively. Ordinarily, any payment that is based to any extent on billed charges, including but not limited to certain outlier payments, is subject to a prospective audit. Unison ordinarily pays a preliminary estimate of 85% of the amount claimed while that audit is being conducted, with the final payment being adjusted in light



of the audit results. Access to records and cooperation with audits, both by Unison and various government oversight agencies, is a mandatory element of payment, whether on a network participating or non-participating basis. Unison may be required to share audit findings with the government agencies that oversee the public sector health plans we serve.

Unison also recognizes that fraud and abuse can be an internal problem. All our employees undergo a thorough background check before commencing work. Our Audit Department regularly conducts inquiries as to payroll records, expense reports, adjudicated claims and enrollment verifications to closely monitor and detect potential employee fraud and abuse.

Member waste or abuse is detected through the monitoring of special claims audits, member profiling/claims histories, provider or pharmacy complaints and enrollment verifications. Where permitted, Unison will either disenroll or employ a lock-in program to help control members whose conduct demonstrates a pattern of fraud and abuse.

16.2 HIPAA

Unison is proud of its success in implementing the required HIPAA standards. Unison is CLAREDI-certified as to the administrative simplification standards for transactions and code sets. We are capable of interacting directly with providers through HIPAA-compliant EDI transactions. Unison also contracts with a clearinghouse which providers can use to submit and receive non-compliant EDI transactions. If you are interested in communicating with us via EDI, please contact Provider Services.

The companies in the Unison insurance holding company system adopted 'affiliated entity' status for purposes of the HIPAA privacy standards. We use and disclose our members' protected health information (PHI) only for purposes of treatment, payment and health care operations. Copies of the notices that describe our privacy practices for each Unison managed care product can be accessed at www.unisonhealthplan.com (hard copies are available upon request). The Unison ID card reminds our members that, by enrolling in Unison managed care product, they agreed to our limited use of their PHI for appropriate purposes. Unison reminds providers that they are obligated, both by applicable law and the standard provider participation agreement, to obtain the consent of our member, who is their patient, as regards use of PHI for any purposes other than those permitted by law. Providers are also required to inform Unison about any breach of the HIPAA privacy rules in a timely manner and cooperate with reasonable actions designed to remediate the adverse effects of such a breach.

Like all members of the health care industry, Unison is aware of the significant HIPAA security challenges we all face. Unison is committed to adopting and updating its physical, electronic and administrative safeguards to protect our member's PHI. We encourage our network participating providers to adopt similar safeguards, suitable to the associated risks and their individual environments, to further secure PHI.

Providers can learn more about Unison's compliance program or its HIPAA privacy and security practices by contacting Provider Services at 800.600.9007.

17: Provider Dispute Procedures

17.1 Overview

It is Unison's goal to identify, eliminate and prevent provider dissatisfaction by making every effort to maintain open lines of communication. To ensure that provider disputes are resolved in a consistent manner, Unison operates internal provider dispute procedures. If a provider has a complaint or other problem regarding any aspect of Unison's operations, the provider may contact Provider Services to register a complaint and seek resolution.

If a matter cannot be resolved to the provider's satisfaction, the provider can exercise his/her dispute rights in writing. Requests must be received within the time frames specified below and should include all details relevant to the dispute and to the attempts at resolution prior to filing.

17.2 Provider Requests for Medical Necessity Reconsideration

Providers disputing denials based upon the lack of medical necessity (prospective or retrospective) may use an alternative Unison process rather than the dispute process detailed above. This process follows the same requirements and time frames as for other disputes outlined, but requires the written consent of the Unison member. The written member consent must accompany the provider's request for a first level medical necessity review. External review of provider requests for medical necessity reconsideration is conducted in accordance with procedures established by the Delaware Department of Health and Social Services. Providers must request such review within 15 days of the provider's receipt of the decision letter regarding the second level dispute

17.3 Provider Disputes

Set forth below is a brief description of Unison's various dispute processes. Providers may obtain further information regarding specific situations by contacting Provider Services. Providers may dispute the following decisions by Unison:

- Denial of a claim or payment authorization request (failure to follow procedures or medical necessity guidelines)
- Credentialing or re-credentialing denial
- Provider contract termination by Unison.

17.4 Dispute of Denied Claims and Payment Authorization

Claims and requests for payment authorization may be denied for failure to follow required procedures or Unison's UM/QI plan (ex: failure to obtain required prior authorization or submit claims on time). While Unison encourages providers to seek informal resolution of claim disputes through Provider Services, the formal dispute process must be initiated within 45 days of Unison's remittance advice or other notice of payment denial. Disputes of denied claims must be submitted in writing to:

Grievance/Appeal Coordinator
Unison Health Plan of Delaware
1001 Brinton Road
Pittsburgh, PA 15221

Providers should not re-submit denied claims or send disputes to the Claims Department. Disputes must

include all supporting documentation and specify all reasons why the provider believes Unison's original decision is in error. Disputes over payment will generally be decided within 30 days of receipt. The provider may request an extension.

17.5 Appeals of Credentialing Decisions and Contract Termination Decisions

Providers may request review of Unison's credentialing decision or other professional review action. Professional review actions are peer review actions subject to all protections provided by law and are reviewed pursuant to Unison's Quality Improvement provider dispute process (as amended from time-to-time). Currently, such disputes are reviewed by a panel of Unison's participating providers. Providers have the right (1) to appear and participate in person; (2) to submit verbal and written evidence; and (3) to be represented by an attorney in such proceedings. Providers seeking review of professional review actions should submit their dispute in writing via certified mail within 30 days of the date of the professional review action notice to:

Medical Director
Unison Health Plan of Delaware
1001 Brinton Road
Pittsburgh, PA 15221

The provider will receive a hearing notice setting the time, date and place of the hearing and relating the provider's rights during the hearing process. A hearing will be held at least 30 days from the date of the hearing notice.

Providers seeking reconsideration of credentialing decisions involving the failure to meet baseline credentialing criteria may submit additional information for review by the plan's Credentialing Committee. Unison's medical director will have sole discretion in determining whether the provider's credentialing application, along with the additional information, will be forwarded to the Credentialing Committee for reconsideration. Providers disputing contract termination decisions should, upon receipt of Unison's decision, immediately contact Provider Services.

17.6 Arbitration

Providers may also be able to seek review of any dispute through the arbitration process, as set forth in the provider agreement, if applicable. Providers are generally required to exhaust all available internal dispute processes before seeking arbitration.

17.7 Provider Dispute Process Revisions

The provider dispute process described herein is subject to change, without notice, to accommodate revisions in applicable Federal and state law. If you have any questions, contact Provider Services.

17.8 Member Appeals, Grievances and State Hearings

The provider may reference the member handbook provided with this manual or contact Unison to request our policies and procedures for more detailed information regarding the member dispute process.

18: Member Grievance and Appeals Procedures

Unison's member complaint and grievance procedures differ based on the rules and regulations of the government agency that oversees our health care plans. A brief description of the member dispute process is included in the following section. The provider may contact Unison and request a copy of the member handbook or Unison's policies and procedures for more detailed information regarding the member dispute process, including deadlines for filing member disputes.

18.1 Member Appeal Process

The member, or authorized representative with the written consent of the member, may file an appeal regarding a Unison action within 90 days of the date of the action. An action is any reduction, suspension, termination, denial, limited authorization or untimely delivery of a service or denial of payment for a service. The member may request that the authorized representative assist or represent the member during the process and be present during the review. These requests must be written requests sent to the following address:

Grievance and Appeals
Unison Health Plan of Delaware
1001 Brinton Road
Pittsburgh, PA 15221

Member appeals are reviewed and a notice of the decision will be sent within 30 days of receipt. This period may be extended up to 14 calendar days upon member request or where Unison demonstrates that the need for additional information is in the member's best interest.

Unison will review the member's appeal in an expedited manner if the member's treating provider certifies that the member's health will be harmed by deciding the appeal in the regular appeal time frames. The certification must include the clinical rationale and member-specific facts to support the provider's opinion. The appeal will be reviewed and a notice of the decision will be sent within three (3) working days of its receipt of the expedited appeal request. The member will also be notified of the decision promptly by telephone.

18.2 Member Grievance Process

The member, or an authorized representative with the written consent of the member, may file a grievance with Unison to express dissatisfaction with any aspect of Unison's or a provider's operation, provision of health care services, activities or behaviors, other than an action, within 90 calendar days of the date that the member became aware of the issue. Member grievances are reviewed and a notice of disposition will be sent within 45 calendar days of receipt. This period may be extended by up to 14 calendar days upon member request or when Unison demonstrates that the need for additional information is in the member's best interest.

18.3 State Fair Hearings

The member, or an authorized representative with the written consent of the member, may also request a state fair hearing with the Delaware Department of Health and Social Services regarding any reduction, suspension, termination, denial or untimely delivery of a service or denial of payment. The member does not need to exhaust Unison's appeal process before requesting a state fair hearing. The request must be filed within 90 calendar days of the date of Unison's action or the date of Unison's written appeal



decision. Requests must be mailed to:

DSS Fair Hearing Officer
Herman M. Holloway Campus, Lewis Building
P.O. Box 907
New Castle, DE 19720

Providers cannot use the hearing process to address claims payment disputes over failure to follow Unison procedures. Providers may file appeals and grievances verbally or in writing.

18.4 Continuation of Services

The member may continue receiving services or items until a decision is made about his or her appeal or state fair hearing if the member is receiving the services that were denied, reduced or terminated, the authorization period has not expired, the request for appeal or state fair hearing is hand-delivered or postmarked within ten (10) days of the date of the notice or the intended effective date of the proposed action, whichever is later, and the member requests the extension of benefits. The member may be liable for the cost of any continued benefits at the discretion of Unison or the Delaware DHSS.

19: Federal Deficit Reduction Act and False Claims Act

Being a service provider in the government sponsored health plan arena comes with substantial responsibility in the areas of compliance and preventing, detecting and responding to fraud, waste and abuse. There are many rules and policies with which we all must comply. Specifically, Unison is committed to preventing health care fraud, waste and abuse and fulfilling its obligations to comply with applicable federal and state laws including, but not limited to, Section 6032 of the Federal Deficit Reduction Act and the rules and regulations of the Medicare Advantage and Part D programs. Section 6032 of the Federal Deficit Reduction Act of 2005 requires us to provide information to our contractors on the Federal and state false claims acts. The following has been drafted to assist us in fulfilling our compliance obligations.

The Federal False Claims Act is a statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The Act establishes liability for any person who knowingly presents or causes to be presented a false claim to the United States government for payment. People can be prosecuted under the Act for a variety of conduct that leads to the submission of fraudulent claims to the government. Penalties for violating the Act can be up to three times the value of the false claim, plus fines.

To encourage individuals to come forward and report misconduct involving false claims, the Act includes a “*qui tam*” or whistle-blower provision. This provision essentially allows any person with actual knowledge of false claims activity to file a lawsuit on behalf of the U.S. government. Individuals seeking whistle-blower status must meet several criteria including but not limited to being the original source of the information. If the lawsuit is successful (after being prosecuted by the government), the whistle-blower may receive an award ranging from 15 to 30 percent of the amount recovered by the government.

In addition to a financial award, the Act entitles whistle-blowers to additional relief, including employment reinstatement, back pay and any other compensation arising from retaliatory conduct against the whistle-blower for filing an action under the Act or committing other lawful acts, such as providing testimony or assisting in a False Claims Act action.

States in which Unison does business have laws that contain civil or criminal penalties for false claims that are in addition to the penalties provided in the Act. Certain states also have whistleblower protections similar to the Act. In Delaware, the applicable laws are Delaware Statutes TI 6 Sect. 120 1-1209.

Unison’s compliance plan and various departmental policies and procedures help ensure Unison’s compliance with the Act and the various state false claims laws, as well as to detect and prevent fraud, waste and abuse in federal health care programs. Team members and the third parties that contract with Unison, including but not limited to health care providers and other entities to whom Unison has delegated obligations, must abide by Unison’s compliance plan, which includes Unison’s code of ethics and the relevant policies and procedures in this regard, all of which are discussed above. Please see the compliance page link on the Unison website at www.unisonhealthplan.com for the most up to date version of the Unison compliance plan and Unison’s policy on fraud, waste and abuse. For more information on this topic, please contact Unison’s compliance officer or Legal Department.

