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Section 1 Introduction: UniCare PPO

UniCare is a family of companies that designs and administers health benefit plans to members throughout the United States. The UniCare companies include UniCare Life & Health Insurance Company, UniCare Health Insurance Company of the Midwest (IL and IN only), UniCare Health Plans of the Midwest, Inc. (HMO in IL and IN only), UniCare Health Insurance Company of Texas (TX only) and UniCare Health Plans of Texas, Inc. (HMO only in TX), all of which are separately incorporated and capitalized subsidiaries of WellPoint Health, Inc., one of the country’s largest publicly traded health benefit companies.

UniCare is committed to working with its independently contracted physicians, other health care professionals and members to provide a high level of satisfaction in delivering quality health benefits. The UniCare PPO Physician Operations Manual is an integral part of this commitment.

This manual is a summary of some of UniCare’s more significant policies and procedures. UniCare reserves the right to modify, amend or implement new policies or procedures without notice. In those instances where information in this manual differs from that in the Provider Agreement, the Agreement takes precedence over the manual.

Network Services
Network Services has two distinct functions: contracting and relations. Our staff supports the network through the contracting, credentialing and recontracting processes and provides ongoing education and support to healthcare professionals and their office staffs.

How To Reach Us

Illinois Office 1-800-700-0668
Houston TX Office 1-888-697-3790 (Zip codes 77000 – 78999)
Plano TX Office 1-888-697-3791 (Zip codes 75000 – 76200)
Alexandria VA/MD/DC Office 1-800-871-7888
Other Mid-Atlantic Locations, CO, NV 1-805-557-5219
New York City Office 1-805-557-5222

Provider Responsibility for Notification of Changes
Providers who have a direct contract with UniCare should submit notifications of change of practice name or affiliation, TIN, address, phone number or other demographic data on the provider’s office letterhead stationery to UniCare Network Services as soon as possible. Notifications may be faxed to the appropriate number below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois</td>
<td>312-234-8222</td>
</tr>
<tr>
<td>Houston</td>
<td>713-479-4288 (Zip codes 77000 – 78999)</td>
</tr>
<tr>
<td>Plano</td>
<td>972-599-6373 (Zip codes 75000 – 76200)</td>
</tr>
<tr>
<td>Alexandria VA/MD/DC</td>
<td>703-933-2881</td>
</tr>
</tbody>
</table>

Providers who do not have a direct contract with UniCare should submit notifications of change of practice name or affiliation, TIN, address, phone number or other demographic data on the provider’s office letterhead stationery to the appropriate network.
Section 1 Introduction: UniCare PPO

UniCare Provider Website

www.unicare.com

Visit the UniCare Provider Web Site to obtain additional information about
• medical policies
• formulary
• HIPAA
• fee schedule updates
• provider manuals
• internet provider finder

The website also features articles and other helpful resource materials for providers.
Section 2 Eligibility: UniCare PPO

Eligibility is a distinct term that refers to a member’s coverage under a Benefit Agreement. It does not include the type of benefit covered. For example, a member might be eligible under his/her employer’s health benefit plan agreement, but may not have coverage, i.e. benefits, for the type(s) of services rendered.

Verifying Eligibility
There are two ways to verify a member’s eligibility: via the UniCare AccessPoint website or by calling Customer Service at the number on the member’s ID card.

AccessPoint
AccessPoint website is an online tool that allows providers to connect to UniCare member eligibility, benefits and claims status. Extended hours make it easy to obtain and print information outside, as well as during, normal office hours.

To set up an account:
1. Link from unicare.com
2. Go to https://provider2.unicare.com/wps/portal/ebpmyunc/registration
3. Call Network Services at 1-888-697-3790 to begin the process.

Each eligible user will be issued a password that permits access to a member’s unique information. All providers are able to obtain eligibility and benefits information. Only providers who have submitted claims can obtain claims status for services they have rendered.

Customer Service
Customer Service can provide information such as coverage limitations and/or exclusions as well as whether the member’s policy includes supplemental benefits or riders. Confirmation of eligibility does not guarantee payment.

To verify a member’s eligibility for coverage under a UniCare plan or to obtain benefit information, call the toll-free Customer Service number on the member’s identification card.

If the member’s ID card is not available, contact a UniCare representative at 1-877-UNICARE during business hours. Representatives can identify the member’s assigned Customer Service unit and route your call to the applicable unit.

Note: The 877-UNICARE representative cannot verify eligibility or provide benefits information. Only Customer Service units or voice response enables you to obtain that data.

Interactive Voice Response (IVR) is an automated system that stores and relays current eligibility data for all UniCare members and is available at all times. The IVR is accessible via the number on the member’s ID card. Be sure to have the member’s nine-digit member number and the physician’s tax identification number ready.

The automated system provides written confirmation of eligibility data to the requestor’s fax number upon request. This confirmation is sent via facsimile when the fax-back option is selected.
Section 2 Eligibility: UniCare PPO

Reciprocity
UniCare members enrolled in other UniCare benefit agreements outside the Texas service area and not currently accessing the UniCare Texas network may access and utilize UniCare Texas providers. In addition, dependents of employees enrolled in plans outside the UniCare service area may access and utilize UniCare Texas providers if such dependents live in the Texas service area. Providers are required to accept the reimbursement amounts agreed to under their UniCare Agreement for provision of such services.

Identification Cards
All members are issued an ID card. The member should present his/her ID card when seeking medical services.

ID cards provide the following information:
1. Member name
2. Member ID number
3. Group number
4. Plan(s) – e.g., Medical and/or WellPoint Pharmacy, Dental
5. Office visit copayment
6. Customer Service telephone number(s)
7. Claims mailing address(es)
8. Prior authorization telephone number
Section 3 Medical Management: UniCare PPO

UniCare’s Medical Management Department works with independently contracted network physicians to promote delivery of health care services that are medically necessary, meet professionally recognized quality standards and are provided in the most appropriate setting. Medical Management uses WellPoint clinical guidelines and Medical Policies/Technology Assessments to support decision making regarding medical necessity and appropriateness of care. Medical Policies are posted on the physician site at www.unicare.com. Member benefit plans describe specific services that are not eligible for benefits. Benefit agreements may limit or exclude a service that is medically necessary. **Nevertheless, all decisions regarding care or treatment remain with the member and physician, whether or not the service is a covered expense.**

UniCare’s medical management benefit decision-making is based solely on appropriateness of care and service. UniCare does not reward any staff for issuing denials and does not offer incentives to encourage underutilization. Case Managers on the Medical Management staff are available to discuss treatment and post-treatment options for catastrophic cases as well as care that may require multidisciplinary or community services. These options can maximize benefits for both members and physicians.

**Medical Necessity Criteria**
Medically necessary services are health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
3. not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

**Medical Management Process**
The Medical Management staff, comprised of M.D.s and R.N.s, determines the medical necessity and appropriateness of care and setting of inpatient and outpatient services. These determinations may be made prospectively, concurrently or retrospectively. The review criteria consider local, regional and national professionally acceptable standards for quality medical care in accordance with state or federal law or regulation. In general, UniCare uses standard guidelines for both inpatient and outpatient services based in part on well-established medical practice protocols such as *Milliman Care Guidelines* for inpatient services. Any case that a nurse is unable to certify based on the criteria is referred to a medical director. Treating physicians may contact a UniCare physician reviewer at 800-852-6127, Ext. 2200, to discuss denial determinations based on medical appropriateness.

**Medical Management Requirements for Preauthorization**
UniCare encourages providers to initiate this benefit preauthorization, since clinical information is required. Providers should call the Customer Service phone number on the member’s ID card with questions concerning a member’s plan requirements. Members’ plan requirements for benefit
preauthorization may vary significantly among plans and lack of preauthorization may result in a reduction of benefit coverage for the member. Be sure to call the Customer Service telephone number on the member’s card to verify the need for benefit preauthorization.

Preauthorization of benefits should be initiated as soon as possible, but not less than three working days prior to a scheduled inpatient hospitalization or outpatient service. If Medical Management determines that additional clinical information is required to make the determination, Medical Management, in compliance with ERISA regulations, will pend the request for authorization in order to request and receive supplementary information for up to 45 days. Exceptions to this pend timeframe are subject to regulatory and state requirements.

In Texas
- Medical Management will respond within three (3) calendar days of receipt of request for non-urgent authorizations and
- Within one (1) hour of receipt of request for urgent care if care is not certified for benefits.

The following information is required when requesting benefit authorization:
- Patient name and ID number
- Patient’s age and sex
- Diagnosis (ICD-9 code)
- Reason for admission/service/procedure
- Scheduled date of admission/service/procedure
- Planned procedure or surgery (CPT code)
- Date of planned procedure, surgery or admission
- Hospital or facility name, if inpatient
- Name and telephone number of treating or admitting physician

If an emergency room visit results in a hospital admission, the physician or member should call the Customer Service phone number on the member’s ID card within 48 hours.

Providers may not bill the member for services that are not authorized for benefits because they are determined to be not medically necessary or inappropriate according to the terms in the member’s benefit plan, unless the member has provided written agreement of financial responsibility in advance of receiving such services.

Providers must contact Medical Management if the patient stay requires additional days beyond those authorized in response to the initial call for benefit preauthorization.

Prospective Review

Inpatient Care
Preauthorization of benefits is required for any elective (non-urgent, non-emergent) admission to a hospital or facility, including those for the following:
- medical and surgical services including normal vaginal and c-section deliveries
- skilled nursing services (including Skilled Nursing Facility)
- psychiatric and substance abuse services (behavioral/mental health)

Note: If there is an unplanned admission for early or threatened labor, premature birth or other high risk situation or complication, the provider must call Customer Service or the Mental Health provider at the phone number on the member’s ID card to determine if certification is required.
Section 3 Medical Management: UniCare PPO

**Outpatient/Ambulatory Care**
Many outpatient services performed in hospital, ambulatory surgical and physician office settings require benefit preauthorization. A complete list of these services may vary by member benefit plan but may include
- Surgical procedures (such as breast surgery, surgery of head/face/nose/mouth/throat/external ears and eyelids, gastric bypass, abdominoplasty/panniculectomy, lipectomy/liposuction, injection of collagen, vein stripping/injection of sclerosing agents, cochlear implants, etc).
- Diagnostic procedures (such as MRIs, CT scans, PET scans, nuclear cardiac scans, etc.)
- Home health care

Call Customer Service to determine if a service or procedure requires benefit preauthorization.

**Emergency Admissions**
If an emergency room visit results in a hospital admission, the physician or member should call the Customer Service number on the member’s ID card as soon as possible.

**Radiology Quality Initiative (RQI)**
The RQI program is a quality initiative (not a preauthorization program), designed to improve the appropriateness of ordering advanced imaging services by physicians. All physicians must contact AIM (American Imaging Management), when ordering elective outpatient advanced imaging services. These procedures include
- CT/CTA scans
- MRI/MRA scans
- Nuclear cardiology studies
- PET scans

Since the RQI program is not a preauthorization program, no procedure will be denied for lack of medical necessity, even if it does not meet the evidenced-based clinical guidelines. However, any procedure considered Experimental and Investigational (E & I) according to WellPoint Medical Policy will not be covered and the member and provider will be informed of this as part of the RQI program. Experimental and Investigational procedures would not be considered for coverage even if the physician does not participate in the RQI process.

**Concurrent Review**
Concurrent review is necessary when the patient stay will exceed the previously approved benefits for length of stay and providers should contact Medical Management to obtain additional authorization of days.

Concurrent review affirms benefits for continuing medical necessity and appropriateness of continued treatment, services or hospitalization. Review of ongoing care is conducted for inpatient hospitalizations that were previously certified as well as for outpatient procedures and ongoing outpatient care that require benefit preauthorization. Concurrent review may also occur in situations where benefit preauthorization was not obtained prior to the hospitalization.

**Retrospective Review**
Retrospective review is performed when a service was performed but was not previously authorized by Medical Management. UniCare will not rescind previous authorizations except in cases of fraud, misrepresentation or where the medical records differ from the information previously provided to UniCare. Providers may request an appeal of a clinical benefit non-certification for up to 120 days.
Section 3 Medical Management: UniCare PPO

Case Management
Case Managers work with physicians to coordinate benefits for complex catastrophic cases and are also available to consult with physicians about difficult or unusual situations. In the event that a member needs services not available through the UniCare network, the case management staff can work with the physician to locate an appropriate setting. Call the Customer Service phone number on the member’s ID card to reach a Case Manager.

Examples of services appropriate for case management include:
- Potential organ and bone marrow transplantation
- Ventilator dependency
- Chronic pain management programs
- Difficult post-discharge placement or post-discharge cases requiring multiple services
- High-risk obstetrics

Appeal of Clinical Non-Certification by Medical Management
Providers may request an appeal of a clinical benefit non-certification for up to 180 days by calling the Customer Service phone number on the member’s ID card or the number on the non-certification notice. Additional clinical documentation may be requested to review the case adequately. The UniCare physician conducting the review will not be the reviewer who made the initial determination.

If UniCare reverses the decision not to certify benefits, a written notice will be issued. If the initial determination not to certify benefits is upheld, UniCare will mail an explanation to the provider and the member.

If the standard appeal outcome is unsatisfactory, the provider may submit a written request for an additional level of appeal, which involves an external independent reviewer. Additional supporting documentation or explanations should be sent to the address on the letter upholding the non-certification.

Subsequent appeal rights may be available depending on the arrangement with self-funded employer groups and/or state laws.

In Texas, if the enrollee’s condition is life-threatening, the enrollee is entitled to an immediate appeal to an independent review organization and is not required to comply with procedures for an internal review of the utilization review agent’s adverse determination. The decision based on this review is final.

Note: A participating provider may not bill the member for services determined to be non-medically necessary or inappropriate under the member’s benefit plan unless the member has agreed in advance to pay these charges and UniCare has denied coverage.
Section 4 Billing/Claims Coding and Submission: UniCare PPO Illinois

This section provides general billing guidelines and UniCare claim submission requirements that are effective as of 1/1/2004, including information about electronic claims submission. Reimbursement policy changes will be posted to the UniCare website, www.unicare.com. Your contract with UniCare requires that you keep all contract terms confidential, including the payment information provided with this disclosure. Should you have questions about this document, please telephone Network Services at 1-800-700-0668.

UniCare uses standard claim guidelines that are current as of the date of service. These guidelines have been developed in part using such references as the guidelines developed by the American Medical Association found in the Current Procedural Terminology (CPT) reference manual. UniCare reserves the right to change its guidelines from time to time without notice.

In the evaluation of claims, UniCare uses various sources including, but not limited to, the AMA position statements from its official publication “CPT assistant”, which is published monthly. The AMA also publishes other official publications such as “CPT changes” annually. Additional sources of information include Medicare Guidelines, updated quarterly, and specialty guidelines from sources such as the American College of Surgery, the Orthopedic Society, The American College of Cardiology and the American College of OB/GYN.

UniCare’s claim processing system incorporates edits based on coding guidelines mentioned above and other sources as well as analyses of medical and technological advances. In the event the claim is not submitted in accordance with UniCare medical policy and guidelines current at the time of service, UniCare may recode the claims as allowed under the UniCare participating Provider Agreements.

All claims submitted by the provider must use the medical services codes listed in the most current version of the AMA Current Procedural Terminology (CPT) and Health Care Procedure Coding system (HCPCS) publications. The provider must submit the medical services codes in accordance with the reporting guidelines and instructions contained in the AMA CPT, CPT Assistant and HCPCS publications.

Effective November 2009, the majority of UniCare’s business utilizes claim editing software called ClaimXten®, published by McKesson. The software includes ClaimCheck®, Clear Claim Connection™ and CMS National Correct Coding Initiative (NCCI) edits.

Updates to UniCare claims processing filters and edits, as a result of annual changes in these reporting guidelines and instructions, shall take place automatically and do not require any notice or disclosure to the provider or any contract amendment.

The presence of a code in published references does not indicate that payment by UniCare is available for the service. At UniCare’s discretion, payment structures are based on benefit plans and health care Provider Agreements.

This document is not intended to replace the provider manual, which contains additional information regarding credentialing, medical management and other issues not directly related to reimbursement. The provider manual is available on UniCare’s website at www.unicare.com.
Electronic Claim Submission
UniCare supports claims submission via Electronic Data Interchange (“EDI”). Payor identification number 80314 is the only number needed to submit claims to UniCare.

UniCare receives submissions from independent third party software vendors, clearinghouses and billing services that collect data. EDI clearinghouses use an EDI network to connect to multiple payors. The EDI network routes communications between physicians and payors and automatically formats data into a standard UniCare format.

Listed below are UniCare approved clearinghouses for physician claims.

<table>
<thead>
<tr>
<th>Clearinghouse</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availity</td>
<td><a href="http://www.availity.com">www.availity.com</a></td>
<td>(800) 282-4548</td>
</tr>
<tr>
<td>Cortex</td>
<td><a href="http://www.cortexedi.com">www.cortexedi.com</a></td>
<td>(800) 485-5977</td>
</tr>
<tr>
<td>CPSI</td>
<td><a href="http://www.cpsinet.com">www.cpsinet.com</a></td>
<td>(800) 711-3774</td>
</tr>
<tr>
<td>ENS</td>
<td><a href="http://www.enshealth.com">www.enshealth.com</a></td>
<td>(800) 341-6141</td>
</tr>
<tr>
<td>Emdeon Business Services</td>
<td><a href="http://www.emdeon.com">www.emdeon.com</a></td>
<td>(877) 363-3666</td>
</tr>
<tr>
<td>Gateway EDI</td>
<td><a href="http://www.gatewayedi.com">www.gatewayedi.com</a></td>
<td>(800) 969-3666</td>
</tr>
<tr>
<td>PayerPath</td>
<td><a href="http://www.payerpath.com">www.payerpath.com</a></td>
<td>(804) 560-2400</td>
</tr>
<tr>
<td>Per Se Technologies</td>
<td><a href="http://www.per-se.com">www.per-se.com</a></td>
<td>(847) 608-7000</td>
</tr>
<tr>
<td>MedAvant</td>
<td><a href="http://www.proxymed.com">www.proxymed.com</a></td>
<td>(714) 979-4467</td>
</tr>
<tr>
<td>SSI Group</td>
<td><a href="http://www.thessigroup.com">www.thessigroup.com</a></td>
<td>(800) 880-3032</td>
</tr>
</tbody>
</table>

Each of the above-named vendors is an independent entity not affiliated with UniCare or any of its affiliates, subsidiaries or parent corporation. Direct questions regarding electronic billing to UniCare EDI Services by phone at (877) 210-4083 or by email at ediunicare@wellpoint.com.

Useful EDI updates also appear on the UniCare web site, www.unicare.com

Paper Claim Submission
Providers who are not set up to submit claims electronically should submit paper claims on the CMS 1500 or equivalent claim form. Claims should be submitted to the address on the member’s identification card and should be accompanied by the preauthorization form if preauthorization of the service was required. If the member’s card is not available, call 1-800-UNICARE for assistance.

The following information is required:
- Member ID/Member HCID number
- Patient name
- Patient date of birth
- Valid ICD9/HCPCS/CPT codes
- Charge amount per line of expense
- Provider tax identification number
- NPI
- Provider address where service was rendered
- Provider license number*
Section 4 Billing/Claims Coding and Submission: UniCare PPO Illinois

*Provider License Number/Professional License*
UniCare utilizes participating physicians’ and practitioners’ state license numbers as unique identifiers along with the zip code for the practice (i.e., the location where services are rendered). Professional claims submitted to UniCare that include this information are expedited. When using a tax identification number for a medical group (i.e., more than one physician bills under the same tax ID), always include the rendering physician’s or practitioner’s name and license number on the claim.

UniCare systems read the physician license number in Field 31 of the CMS 1500. Claims submitted without a state license number may be returned or their processing may be delayed.

Zip code of practice is required to determine claim payment for the following provider types:
- air ambulance
- blood bank
- donor bank
- ground ambulance
- independent laboratory
- medical vendor (e.g., DME, home health, dialysis)
- diagnostic imaging/MRI
- occupational therapy
- optician
- orthotics/prosthetics
- pharmacy
- portable x-ray/laboratory
- clinical laboratory

Clinical Information
Following is a list of claims categories that may routinely require submission of clinical information before or after payment of a claim. Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

1. Claims involving preauthorization/precertification or some other form of utilization review including but not limited to
   - claims pending for lack of preauthorization/precertification;
   - claims involving medical necessity or experimental/investigative determinations;
   - claims for pharmaceuticals requiring prior authorization.
2. Claims involving certain modifiers, including but not limited to Modifier 22.
3. Claims involving unlisted codes.
4. Claims for which we cannot determine from the face of the claim whether it involves a Covered Service; thus a benefit determination requires a medical record review, including but not limited to
   - pre-existing condition questions;
   - emergency service/prudent layperson reviews;
   - specific benefit exclusions.
5. Claims that may contain inappropriate billing.
Section 4 Billing/Claims Coding and Submission: UniCare PPO Illinois

6. Claims that are the subject of an internal or external audit including high dollar claims.
7. Claims for individuals involved in case management or disease management programs.
8. Claims that have been appealed or that are otherwise the subject of a dispute, including claims in mediation, arbitration or litigation.
9. Other situations in which clinical information might routinely be requested:
   • requests relating to underwriting, including but not limited to member or physician misrepresentation/fraud reviews and stop loss coverage issues;
   • accreditation activities;
   • quality improvement/assurance activities;
   • credentialing;
   • coordination of benefits;
   • recovery/subrogation.

Site of Service
Providers whose agreements state that UniCare’s fee schedule is based upon the CMS RBRVS fee schedule must indicate the appropriate site of service on the claim so that UniCare may determine the correct allowable amount consistent with the current practice described by the CMS RBRVS fee schedule. Sites of service that will be reimbursed at the facility reimbursement rate include, but are not limited to, 21, 22, 23, 26, 31, 34, 41, 42, 51, 52, 53, and are subject to change in accordance with changes published by CMS, or its successor, in the Federal Register from time to time.

Claims Filing Deadlines
Physicians should submit claims to UniCare within 180 days after the later of
1. the date of service and
2. the date of the physician’s receipt of the EOB from the primary payor, when UniCare is the secondary payor.

UniCare shall extend the 180-day time period for a reasonable period, on a case by case basis, in the event that a physician provides notice to UniCare, along with appropriate evidence, of circumstances reasonably beyond the physician’s control that resulted in the delayed submission, as determined by UniCare.

Claims Authorizations
All services require the referral and authorization of the member’s Primary Care Physician. Some services also require benefit authorization by UniCare Medical Management. The claims system recognizes claims requiring benefit authorization based on the type of service rendered. When a claim requiring prior benefit authorization is identified, the system searches the medical management system for the corresponding authorization. The authorization notice is a document stating UniCare’s utilization management benefit determination of medical necessity based upon the member’s Benefit Agreement. If a benefit authorization is not found, retrospective medical necessity benefit determination may be made and the claim will be reviewed to determine if service was authorized by the Primary Care Physician. UniCare has published medical policies on UniCare’s website www.unicare.com Claims may be denied for failure to obtain benefit authorization when required. Call the Customer Service number on the member’s ID card to determine if service(s) require prior authorization.

Utilization management benefit determinations made by UniCare are solely for determination of whether the medical and/or hospital services meet the medical necessity criteria set forth in the member’s Benefit Agreement. Benefit authorization does not guarantee the payment of a claim.
however, UniCare will not deny or reduce payment for pre-authorized services based on medical necessity or appropriateness of care unless the physician or provider has materially misrepresented the proposed medical or healthcare service or the physician or provider has substantially failed to perform the proposed medical or healthcare services. The responsibility for claim processing and payment determination rests solely with UniCare.

**Medical Necessity**
Medically necessary services are health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
3. not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

**Preauthorization Number**
Claims for the following services require submission of a UniCare preauthorization number. Additional medical record documentation may be required.

- Durable Medical Equipment (DME) rentals
- Durable Medical Equipment (DME) purchases exceeding $1000
- Infertility treatment
- Home infusion therapy

**Medical Records, Operative and Other Appropriate Reports**
Operative reports and records of the patient’s history may be required for claims for the following services:

- Blepharoplasty
- Breast reduction
- By-report surgeries
- Co-surgeon charges
- Cosmetic surgery
- CPT code ending in 999 (unlisted or by-report)
- Investigational surgery
- Multiple surgeries performed on the same date of service
- Obesity surgeries
- Rhinoplasty
- Septoplasty
Section 4 Billing/Claims Coding and Submission: UniCare PPO Illinois

Member Liability
The only charges for which the member may be liable and may be billed by a UniCare participating hospital, physician or practitioner are
1. deductibles, co-payments and co-insurance amounts required by the member’s Benefit Agreement, and
2. medical services not covered by the member’s Benefit Agreement where the member has agreed in advance in writing to assume financial responsibility. The member’s written agreement of financial responsibility must be specific to the services rendered.

UniCare plan designs may include a deductible that must be met before benefits are payable. Some plans may also have benefit-specific deductibles. The member is financially responsible for the deductible amount(s). In addition, the member is generally responsible for paying a co-payment or co-insurance for services received after all required deductibles have been satisfied. While co-payments and deductibles may be collected at the time the services are rendered, UniCare recommends billing the co-insurance amount upon receipt of the UniCare Explanation of Benefits.

To determine the member’s financial responsibility (i.e., his/her co-payment amount or whether s/he has satisfied any required deductible) contact the toll-free customer service number listed on the member’s identification card. This information is time-sensitive and subject to change upon adjudication of other claims.

Member Liability for Services Not Medically Necessary
Participating physicians and practitioners may not charge a member for medical services where benefits have been denied as not medically necessary under the terms of the Benefit Agreement unless the member has provided written agreement of financial responsibility in advance of receiving such services. The member’s written agreement of financial responsibility must be specific to the services rendered. If the amounts collected exceed the member’s responsibility, the physician or provider is required to issue a prompt refund once the EOB is received.

Coordination of Benefits
Coordination of Benefits (COB) determines responsibility for payment of eligible expenses among insurers providing insurance coverage to the member. When a member has more than one insurance coverage, primary and secondary coverages are normally determined in accordance with the Prime Carrier Rules or as required under the laws of the state in which the member’s Benefit Agreement was issued.

Prime Carrier Rules are often used by insurance carriers industry-wide and have been incorporated into appropriate UniCare benefit agreements. These rules determine the payment responsibilities between UniCare and other applicable group insurers by establishing which insurer is the prime carrier and which is the secondary carrier.

NOTE: The UniCare payment will not exceed the maximum allowable amount as determined in accordance with the UniCare fee schedule or as set for the in the Provider agreement, total charges or the member’s responsibility for Covered Services, whichever is less except as otherwise required by law.
The Prime Carrier Rules normally do not apply to:
- non-group policies (individual policies)
- auto insurance policies
- Medicaid
- CHAMPUS/CHAMPVA

**Third Party Liability**
Third Party Liability (TPL) occurs when a person or entity other than the UniCare member may be liable or legally responsible for the member’s illness, injury or other condition and is, therefore, responsible for the costs associated with the member’s illness, injury or condition. UniCare may be entitled to reimbursement from the member from any settlement the member may receive in those situations.

**IRS Backup Withholding**
The Internal Revenue Service requires UniCare to withhold 30% in tax, called backup withholding if a payee does not furnish UniCare with the correct name and Taxpayer Identification Number combination as shown on the records of the Internal Revenue Service or Social Security Administration (“SSA”). “Payee” refers to all medical service providers.

**Note:** The withhold amount is 30% of the UniCare allowable amount, less any benefit reductions.

Generally, backup withholding begins when
1. A payee has been notified by UniCare that his/her name and/or tax ID does not match the name and/or tax ID on record with the IRS or SSA, and
2. The payee has not responded by submitting a completed and signed Form W-9 within thirty (30) business days from the date noted on the solicitation.

Providers who receive this solicitation should complete the Form W-9 and promptly mail it to

UniCare Corporate Tax Department
1831 Chestnut Street
St. Louis, MO 63103

**NOTE:** Any amounts withheld under the federal tax rules discussed above may not be charged to or reimbursed from the member.

Please direct questions to UniCare’s Tax Department at (888) 246-4893.
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Overpayment and Recovery Procedures
In the event of an overpayment, UniCare seeks recovery of all excess claim payments from the payee to whom the UniCare check was made payable. The procedure for recovery of overpayments involves multiple notifications to payee and allows an opportunity for appeal.

Overpayment Recovery Process
The initial notice regarding overpayment recovery will be provided not later than the 365th day from the original claim payment date; however, active collection efforts will not begin until 30 days after notification of overpayment. The overpayment and recovery process follows:

Day 1 – Overpayment is identified.

Day 3 – 1st Letter is sent, notifying payee of identification of overpayment and that UniCare will begin recovery process through offset of future claims payments or other recovery methods, if the refund is not received by XX/XX/XX (equal to 60th day from day 1). The letter will include the specific claim at issue and amounts for which a refund is due, the basis and specific reasons for the refund request, and a notice of appeal rights.

Day 30 – 2nd Letter is sent to payee requesting overpayment refund, informing payee that UniCare will begin recovery process through offset of future claims payments or other recovery methods if the refund is not received by XX/XX/XX (equal to 60th day from day 1). The letter will include the contact information for UniCare, the specific claim at issue and amounts for which a refund is due, the basis and specific reasons for the refund request, and a notice of appeal rights.

Day 60 – 3rd Letter is sent to payee as a reminder of the overpayment refund due to UniCare. The letter will include the contact information for UniCare, the specific claim at issue and amounts for which a refund is due, the basis and specific reasons for the refund request, and a notice of appeal rights. UniCare will begin to offset future claims payments or internal collection methods, including, but not limited to, referral to collection vendor if the payee has not made arrangements for payment of the refund and has not requested an appeal.

Day 90 – 4th Letter is sent to payee advising that UniCare will refer the overpayment to external collections if payment is not received within 10 days from the date of this letter. The letter will include the contact information for UniCare, the specific claim at issue and amounts for which a refund is due, the basis and specific reasons for the refund request and a notice of appeal rights.

In some situations, UniCare determines that recovery of an overpayment through future claims payments is not feasible, in which case the overpayment may be referred to an external collection agency or handled internally in an effort to recover.

Refund of Overpayment
Overpayment refund checks should be made out to UniCare and mailed to:

UniCare Cost Containment and Overpayment Avoidance (CCOA)
P.O. BOX 5019
Bolingbrook, IL 60440

Include the following information when submitting an overpayment refund:
• Copy of the claim Explanation of Benefits statement, sent from UniCare
• Refund amount and reason for the overpayment refund
Section 4 Billing/Claims Coding and Submission: UniCare PPO Illinois

If the Explanation of Benefits statement is not included, provide the following identifying information:

- Name of patient
- Patient’s date of birth
- UniCare subscriber identification number
- UniCare claim number
- Date of service
- Name and address of provider
- Provider Tax ID Number
- Amount originally billed
- Amount of original claim payment
- Refund amount
- Reason for the overpayment refund
- Name and telephone number of sender, in case we need additional information related to the refund

Telephone UniCare Cost Containment and Overpayment Avoidance (CCOA) between the hours of 8:00 AM to 4:00 PM Monday – Thursday, 8:00 AM to 3:00 PM Friday, Central Standard Time at 866-297-2764 or in writing at:

UniCare Cost Containment and Overpayment Avoidance (CCOA)
P.O. BOX 5019
Bolingbrook, IL 60440

**Overpayment Appeal Process**

In the event of an overpayment, UniCare seeks recovery of all excess claim payments from the payee to whom the UniCare check was made payable. The procedure for recovery of overpayments includes multiple notifications to payee and allows an opportunity for appeal.

If the payee disagrees with the request for overpayment refund, an appeal should be sent within 45 days of first date of notification of overpayment for consideration. All collection efforts, including offsets of future payments are pended until the appeal process is completed.

Appeals can be requested by telephone between the hours of 8:00 AM to 4:00 PM Monday – Thursday, 8:00 AM to 3:00 PM Friday, Central Standard Time at 866-297-2764 or in writing at:

UniCare Cost Containment and Overpayment Avoidance
P.O. Box 5019
Bolingbrook, IL 60440

**Split Year Claims**

Two claims are required for services that begin before December 31 but extend beyond the end of the calendar year: one claim for services incurred through December 31 and a second claim for services beginning January 1. This is necessary to track calendar year deductibles and co-payment maximums.
Fee Schedule, Reimbursement, Coding and Bundling Guidelines
As outlined in the Provider Agreement, once a claim is determined to be payable, the maximum allowable rate is the fee schedule associated with each code or such other payment arrangement specified in the Agreement. Conversion factors and unit values are not included. Provider-specific fee schedules may be provided on paper, CD-Rom or diskette on request.

In the evaluation of claims, UniCare uses various sources including, but not limited to, the AMA position statements from its official publication, “CPT assistant”, which is published monthly. The AMA also publishes other official publications such as “CPT changes” annually. Additional sources of information include Medicare Guidelines, updated quarterly, and specialty guidelines from sources such as the American College of Surgery, the Orthopedic Society, The American College of Cardiology and the American College of OB/GYN.

The claim processing system utilized by UniCare incorporates edits based on coding guidelines mentioned above and other sources as well as analyses of medical and technological advances. In the event the claim is not submitted in accordance with UniCare medical policy and guidelines current at the time of service, UniCare may recode the claims as allowed under the UniCare participating provider agreements.

NOTE: Inclusion of a procedure in the CPT codebook does not imply UniCare coverage or reimbursement.

UniCare uses these guidelines for administrative purposes such as claims processing and the development of guidelines for medical review and medical policy. For hospital claims UniCare generally uses Milliman USA guidelines along with UniCare’s own medical policies, which are published on www.unicare.com.

Effective 1/1/2009, UniCare modified its reimbursement methodology. The revised methodology provides a standardized UniCare proprietary fee schedule that is not tied to the CMS fee schedule.

Provider Agreements will include one of two rate exhibits
1. Prevailing Exhibit: 100% of the market prevailing fee schedule as determined by UniCare
2. Carveout: Variation to the Prevailing Rate determined by negotiating rates acceptable to UniCare
   • Carveout codes are limited in both number and variation to the market prevailing rate as established or approved by UniCare
   • Only carveout codes receive additional reimbursement; remaining codes are paid at the prevailing rate.

Modifications to the proprietary fee schedule that result in material adverse changes will be communicated to providers 90 days prior to the change effective date. Proprietary fee schedules will be evaluated annually.

Following are general UniCare claims submission and reimbursement guidelines.
Section 4 Billing/Claims Coding and Submission: UniCare PPO Illinois

System Edits
Claim system edits are in place for claims processing and are generally based on CPT Coding Guidelines unless otherwise indicated. Claims not submitted in accordance with CPT Coding Guidelines cannot be readily processed and are subject to return or rejection. Some claims may be subject to UniCare medical review. The Medical Review Unit may review the claim and medical records to ensure accurate billing. In the event the claim is not submitted in accordance with UniCare medical policy and coding guidelines current at the time of service, UniCare may recode the claim as allowed under the UniCare participating provider agreement.

Edit Descriptions
An **Incidental Procedure** is performed at the same time as a more complex primary procedure. The incidental procedure does not require significant additional physician resources and/or is clinically integral to the performance of the primary procedure.

**Mutually Exclusive Procedures** are two or more procedures usually not performed during the same patient encounter on the same date of service. Mutually exclusive rules may also govern different procedure code descriptions for the same type of procedure for which the physician should be submitting only one procedure.

**Procedure Rebundling** occurs when two or more procedures are used to describe a service when a single, more comprehensive procedure exists that more accurately describes the complete service performed by a Provider. In this instance the two codes may be replaced with the more appropriate code.

**Base Code Quantity.** Identifies a claim reporting a primary service with a base code that has a quantity greater than one, rather than reporting the appropriate add-on code. The line item with the base code quantity greater than one will be denied and replaced with a line item that allows payment for only one procedure. This edit also identifies multiple occurrences of a base code on separate lines and the additional base code line items will be denied. (See CPT Appendix D for list of add-on codes.)

**Add-on Code Without Base Code.** Identifies situations where an add-on code has been billed without the related primary service/procedure (base code). According to the CPT manual, “Add-on codes are always performed in addition to the primary service/procedure (base code), and must never be reported as a stand-alone code.” If an add-on code is submitted without the base code, it will be denied. Therefore, it is important that the add-on code and base code be submitted on the same claim. In addition, if the base code is not eligible for reimbursement, the add-on code will also be denied.

**New Patient Evaluation and Management (E/M).** Identifies new patient E/M codes billed for established patients. According to the AMA, “A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the last three years.” When detected, the new patient E/M code will be denied.
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**HCPCS and CPT Codes**
Current HCPCS and CPT manuals must be used, since many changes are made to these codes annually. These manuals may be purchased at any technical book store or by writing to

Book and Pamphlet Fulfillment OP-3411/8
American Medical Association
P.O. Box 10946
Chicago, IL 60610-0926, or by calling

HCPCS: (800) 633-7467
AMA/CPT: (800) 621-8335

**Unlisted Procedure or Service.** There may be services or procedures performed by physicians that are not found in the CPT codebook. Specific code numbers have been designated for reporting unlisted procedures.

A description of the service should always accompany a bill for an unlisted procedure code. This information will expedite claim processing. UniCare’s Medical Review Unit will review these services. Medical record review may also be required to determine benefits for an unlisted procedure or service.

**Reimbursement for HCPCS Level II Codes**
- **Durable Medical Equipment, Supplies (including, but not limited to, infusion therapy supplies), Prosthetics and Orthotics.** The maximum allowable amount will normally be based on whether the equipment is new, used or rented as identified by the HCPCS Level II Code Modifier. UniCare may designate certain items as “rental only” or “purchase only” or “rent to purchase.” For “rent to purchase” items, the maximum allowable is the UniCare-determined purchase price; rental will not exceed the purchase price. Codes not identified by a modifier as “purchase” will be considered rentals.

- **Other HCPCS Codes.** The maximum allowable reimbursement is based on UniCare-selected published market data, including but not limited to sources such as the Drug Topics Red Book, Medispan and First Databank and are reviewed annually. Self-injectable drugs for home use and all oral prescription drugs dispensed in the physician’s office will be denied as not payable and the physician may not bill the member. These services must be provided by a licensed UniCare network pharmacy for the member to obtain the maximum benefit under the pharmacy benefit plan.

**Note:** UniCare does not compensate for hot and cold packs when billed on the same date of service as other codes.
Section 4 Billing/Claims Coding and Submission: UniCare PPO Illinois

CPT Codes Not Eligible for Payment include, but are not limited to the following:

CPT Code A4649 Surgical Supply; miscellaneous.
CPT Code 36000 Introduction of needle or intra-catheter, vein.
CPT Code 99051 Services provided in the office during regularly scheduled evening, weekend or holiday office hours in addition to basic service.
CPT Code 99053 Services provided between 10pm and 8am at 24-hour facility, in addition to basic service.
CPT Code 99056 Services typically provided in the office, provided out of the office at request of patient, in addition to basic service.
CPT Code 99058 Services provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service.

CPT Code 99060 Services provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service.
CPT Code 99070 Supplies and materials provided by the physician over and above those usually included with the office visit or other services. Providers should use HCPCS Level II codes, which give a detailed description of the service provided.
CPT Code 99080 Special reports such as insurance forms or more than the information conveyed in the usual medical communications or standard reporting forms.

Prolonged Physician Services

CPT Codes 99354-99355 Prolonged physician service in the office or other outpatient setting requiring direct face-to-face patient contact beyond the usual service. (E.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting.)

The face-to-face Prolonged Services codes were designed to separate direct physician services from time spent coordinating patient care, prior to or following a patient encounter. However, UniCare does not reimburse prolonged service codes when used to designate time spent counseling the patient during the performance of an E/M service.

Prolonged services are expected to be reported and may be eligible for separate reimbursement in a few acute or unique situations:

- An example of an acute situation may be respiratory distress with shortness of breath or severe wheezing, or a severe allergic reaction with systemic pruritus or swelling. Physician treatment in this case may require significant additional physician time to monitor response to treatment provided beyond what is typically included in an E/M or other reported services.
- In addition, there may be a unique situation which may require hours of direct face-to-face physician involvement for which there is no other appropriate CPT code to report.
- CPT codes 99354-99355 may be eligible for separate reimbursement when the E/M service performed and reported is based on the required component factors (which are history, exam, and decision making, but not counseling or coordination of care) and is not based on time, and:
  - The standard office record clearly documents the content of the specific face-to-face physician service provided, beyond what is typically included in the E/M service
  - Start and stop times are noted and are at least 30 minutes or more beyond the typical time of the reported E/M. Anything less than 30 minutes is considered part of the work effort of the base E/M.
  - For additional 30 minute increments, documented service and time frames need to be at least 15 minutes or more to be reported.
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CPT Codes 99356-99357 Prolonged physician service in the inpatient setting requiring unit/floor time beyond the usual service.
CPT Codes 99358-99359 Prolonged evaluation and management service before and/or after direct face-to-face patient care. (E.g., review of extensive records and tests, communication with other professionals and/or the patient/family.)

Modifiers
A modifier indicates that the procedure performed by the physician has been altered by some specific circumstance but has not changed in its definition or code. The presence of a modifier in the current CPT, HCPCS or other procedure manuals does not necessarily indicate that the service is payable by UniCare. UniCare retains discretion in the determination of payment structures.

Modifiers may be billed in accordance with the CPT and HCPCS manual to indicate the following:
- A service or procedure requiring a professional or technical component. (Not all services are considered to have professional or technical components; some procedures are considered professional only or global only.)
- A service or procedure performed by more than one physician and/or in more than one location.
- A service or procedure that increased or was reduced.
- A service or procedure rendered more than once.
- Partial procedure performed.
- Adjunctive services.
- Bilateral procedures.
- Unusual events occurred.

Following are the most commonly used modifiers.

Modifier 22 Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. This code will be pended for medical review if medical records are attached, processed without review if records are not attached. Additional allowance will be made on a case-by-case basis when supported in medical documentation (allowance +20%).

Modifier 24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. Certain bundling edits will be overridden when billed according to AMA/CPT guidelines. In addition to reporting modifier 24, the diagnosis should be different from the diagnosis for the surgical period. A different diagnosis occurs when the first three digits of the two diagnoses differ. Supporting documentation is not required with claim submission, but may be requested.

Modifier 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service: This modifier can be submitted with Evaluation and Management services and with ophthalmology examinations and evaluation services. UniCare generally will recognize modifier 25, for payment purposes, when modifier 25 is appropriately reported from both a clinical and coding perspective.
 Modifier 26 Clinical Pathology Codes: Certain procedure codes when used in conjunction with a modifier describe either one or a combination of a physician component and a technical component of a service. When reporting the physician component of a code only, Modifier 26 should be used. When reporting with clinical pathology codes, no payment will be made except for select codes that require a separately identifiable professional interpretation beyond the technical component. The list of pathology codes for which Modifier 26 may be payable may change from time to time and is based in part of CMS guidelines.

Services billed without a modifier 26 are considered to be global services. Cardiac catheterization services should be billed with Modifier 26 to reflect the professional component.

Modifier 50 Bilateral Procedure: The maximum allowable rate for the surgical service may be increased by up to 50% for the bilateral procedure unless the service is otherwise identified as a single code.

Modifier 51 Multiple Procedures: Multiple Surgical Reduction rule (100%, 50%, 50% of maximum allowable rate) is normally applied to claims for multiple procedures performed at the same operative session. See Multiple Surgeries section following.

Modifier 52 Reduced Service: A 50% reduction will be applied to any reimbursement for services associated with this code. If these services are provided in conjunction with other surgical procedures, the standard approach to reimbursement for multiple surgeries will also apply.

Modifier 53 Discontinued Procedure: A 50% reduction will be applied to any reimbursement for procedures associated with this code. If these procedures are provided in conjunction with other surgical procedures, the standard approach to reimbursement for multiple surgeries will also apply.

Modifier 54 Surgical Care Only: Claim determination is normally based upon 70% of maximum allowable rate of the surgical procedure.

Modifier 55 Postoperative Management: When billed with a surgical CPT code claim determination is normally based upon 30% of the maximum allowable rate of the surgical procedure. If billed with an office visit code, there is no value change.

Modifier 56 Preoperative Management: When billed with a surgical CPT code claim determination is normally based upon 10% of the maximum allowable rate of the surgical procedure.

Modifier 62 Co-surgeons: Claim determination is normally based upon 125% of maximum allowable rate and 50% is normally allowed to each surgeon.

Modifier 63 Procedure Performed on Infants less than 4 kg: Claim determination is normally based upon 120% of maximum allowable rate.

Modifiers 73, 74 Discontinued Outpatient Hospital/Ambulatory Surgery Center Procedure Prior to/After Administration of Anesthesia: No reimbursement, since code is inappropriate for professional provider billing.

Modifier 78 Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period: Claim determination is normally based upon 70% of maximum allowable rate.

Modifiers 80, 81, 82 Assistant Surgeon: Claim determination is normally based upon 16% of the maximum allowable rate of the surgical procedure.
Modifier 99 Multiple Modifiers: All claims billed with this modifier are subject to medical review.

Modifier AS Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist services for assistant at surgery: Claim determination is normally based upon 14% of the maximum allowable rate.

Duplicate Professional and Technical Components
This rule considers component procedures (professional or technical) a duplicate if the global procedure is billed by the same provider for the same member on the same date of service. This edit is based on CMS coding guidelines; procedures with a “PCTC Ind” indicator in the National Physician Fee Schedule Relative Value File are included in this list of procedures.

Technical Only or Complete Service for Hospital Inpatient or Outpatient
No reimbursement. Physicians who provide clinical lab, pathology, radiology or other diagnostic testing services to hospital inpatients or outpatients shall only be reimbursed for the professional component fee allowance (when the code has a separate professional component RVU assigned based on CMS guidelines). There will be no reimbursement to the physician for the technical component only, or the complete service. Such reimbursement has been included in the payment to the hospital.

Anesthesia Modifiers QK, QX Medical Direction Claim determination is normally based upon 50% of the allowable rate.

Anesthesia
Rendering a patient insensible to pain during surgical, obstetrical and certain other medically necessary procedures caused by the administration of a drug or by other medical interventions.

General anesthesia. A state of unconsciousness with the absence of pain and/or sensation, produced by anesthesia agents that affect the entire body. Drugs that produce this state are administered intravenously, rectally, intramuscularly or by inhalation.

Regional anesthesia. The absence of pain and/or sensation produced by introducing an agent that interrupts the sensory nerve conduction to a specific area (region) of the body.
- Field block: Introduction of a local or topical anesthetic to produce the absence of pain and/or sensation to an operative area of the body.
  - Local anesthesia may be used in more than one area of the body. Any agent used to produce the absence of pain and/or sensation other than to the entire body is a local anesthetic.
  - Topical anesthesia includes local agents applied to the surface in areas such as eyes and mucous membranes where injections are not recommended or possible. Eye drops, creams and sprays are common topical agents.
- Nerve block: Introduction of an anesthetic agent close to a nerve so that conduction is cut off. Spinal and caudal anesthesia are types of nerve blocks into the spinal column. These types of anesthesia are often desired for abdominal or obstetrical surgery and affect a large area of the body.
Policy
Charges for anesthesia administration may be eligible for contract benefits when
1. provided by a physician, typically an anesthesiologist (MD, DO) or a Certified Registered Nurse Anesthetist (CRNA); and
2. performed in conjunction with a covered surgical, medical, obstetric or radiology service.

Anesthesia Services Most Often Eligible for Payment
- Services of an anesthesiologist or CRNA billed by a hospital on UB-92 are considered ancillary services and reimbursed according to the terms of the hospital agreement.
- Anesthesia, given in conjunction with a covered surgical or obstetrical procedure, where the anesthesiologist or CRNA is in constant attendance with the patient administering anesthesia, monitoring and managing life functions, managing unconsciousness, and/or managing fluid therapy (regardless of where the surgery is performed). Such care includes pre-anesthetic evaluation, intra-anesthetic record keeping and post-anesthetic follow-up.
- Anesthesia services for continuous epidural on obstetrical procedures requires the following information:
  1. Type of anesthesia (epidural, lumbar or caudal, or spinal)
  2. Start and stop time of labor anesthesia
  3. Start and stop time of delivery anesthesia
  4. Type of delivery performed
- Anesthesia, given in conjunction with certain covered non-surgical procedures, when the procedure requires that the patient be kept absolutely still or is too painful to be performed without anesthesia as identified with either a modifier code or a procedure code.
- Anesthesia services identified as qualifying circumstances (by the use of additional CPT codes 99100, 99116, 99135 and 99140).
- Anesthesia with Medical Direction (QK, QX, QY) will allow for allocation of payment between supervising Anesthesiologists and CRNA(s).
- Anesthesia physical status modifiers P1 and P2. (Modifiers P3 – P6 are normally eligible for payment in accordance with ASA guidelines.)

Anesthesia Services Often Not Eligible for Payment
- Anesthesia given in conjunction with a non-covered surgery or non-covered medical procedure.
- Field block local anesthesia administered by the surgeon who performed the surgery. Field block local anesthesia is included in the surgery value; however, the cost of the materials for the local (e.g., anesthetic agent) is eligible for benefits.
The usual preoperative and postoperative visits, anesthesia care during the procedure, administration of fluids and/or blood and the usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry).

**Exception:** The following unusual forms of monitoring are not included in the price of anesthesia and may be payable in addition to the anesthesia services:

- intra-arterial, CPT 36620
- Swan-Ganz, CPT 93503

Anesthesia services billed by the same provider (surgeon, radiologist or endoscopist) performing the procedure requiring the anesthesia.

### Special Circumstances

- **Pain management.** Intravenous administration of drugs, where a machine controls the dosage and duration.
  - Patient Controlled Analgesia (PCA). UniCare often allows the initial consultation or set-up. If subsequent visits are billed, claims are subject to medical review for determination of medical necessity in accordance with the criteria in the Benefit Agreement.
  - Continuous Epidural (non Obstetric). This is extremely rare and usually billed for hospice care end term and is subject to Medical Review for benefit determination.

- **Nerve Block.** Administered by a surgeon, and performed by injection for the purpose of anesthesia or therapeutic pain control.
  - A nerve block procedure billed either with an anesthesia CPT or the nerve block procedure code with Modifier 30 or Modifier AA through AG performed in conjunction with a surgical procedure is considered anesthesia services. UniCare normally reimburses anesthesia using the base anesthesia unit value only. Time units are not allowed. Nerve block procedures not billed as anesthesia services are considered therapeutic and reimbursed as surgery.
  - **Exception:** Obstetrical claims billed with a nerve block CPT procedure code may be reimbursed as anesthesia.

- **Standby during Percutaneous Transluminal Coronary Angioplasty (PTCA)**

- **Hypnosis.** When used as anesthesia during surgery is subject to medical review.

- **Acupuncture.** Billed as an anesthesia service.

- **Unusual anesthesia.** Billed with Modifier 23. Indicates unusual circumstances.
  - Documentation must be provided to support the unusual circumstances and will be subject to medical review for benefit determination.

### Special Notes

- When two or more anesthesia procedures are billed during the same operative session, the anesthesia allowable amount will be determined by the procedure with the greater anesthesia units plus time units.

- If a second procedure begins more than one hour after the anesthesia end time of the first procedure, both procedures are considered separate operative sessions and the base and time units of each procedure normally are considered separately.
Obstetrical Anesthesia
The time for continuous lumbar epidural, caudal or spinal injection anesthesia when used during labor and delivery (01967) is calculated at one unit for every hour or fraction (e.g., 01- 60 minutes equals one unit; 61-120 minutes equals two units, 121-180 minutes equals three units, etc.). There is no differentiation between continuous epidurals for vaginal and cesarean deliveries. If a scheduled vaginal delivery subsequently results in a cesarean delivery, codes 01967 and 01968 must be billed.

Anesthesia Allowance
The allowable amount for anesthesia services is normally determined by multiplying the sum of the base units for the service and the time units expended by the appropriate conversion factor. Anesthesia time units are normally calculated in units of 15 minutes (in increments of 5 minutes unless noted otherwise).

Anesthesia Time
Anesthesia time units are calculated in units of 15 minutes unless noted otherwise. Total number of minutes must be included on all anesthesia claims in field 24G of the CMS 1500.

Anesthesia Codes and Modifiers
UniCare requires current CPT codes 00100 – 01999 for anesthesia administration claims. (CPT codes 00100 – 01999 identify the section of the body where the procedure was performed, not the type of procedure performed.) UniCare does not allow the practice of billing anesthesia services using surgical codes with a modifier. In addition, when two or more surgical procedures are performed during the same operative session, only the anesthesia procedure with the higher base unit value is allowed for reimbursement.

Multiple Surgeries
Multiple surgery claims are normally priced based on major and minor procedures performed on the same date of service during the same surgical session. The surgical procedure with the highest UniCare unit value is considered the major procedure and is priced at 100 percent of the unit value. The minor surgeries have a lesser unit value and are normally reduced as follows:

- **Incidental Surgery.** A surgical procedure that is performed as part of another surgery and should not be billed separately (commonly referred to as ‘unbundling’). The charge for the incidental procedure is included in the provider’s write-off.

1. **‘As Is’ Surgeries.** Surgeries outside the Integumentary System (CPT range 10040-19499) that are always subsequent procedures (e.g., additional segment, suture of additional nerve). These surgeries are always billed with another surgery and never billed as stand-alone procedures.

2. **Bilateral Surgery.** Surgeries performed through separate incisions to matching parts of the body (e.g., both shoulders). These surgeries are identified either with the surgical procedure and modifier 50, or the surgical procedure billed twice with modifier 50 attached to the second procedure.

3. **Block Procedures.** Surgeries in the Integumentary System that consist of a parent code and subsequent procedures, which merely increase the complexity of the parent procedure. The entire ‘block’ is considered one surgery.
Section 4 Billing/Claims Coding and Submission: UniCare PPO Illinois

Additional Information
1. Major and minor surgeries are priced line-by-line based on the UniCare allowed amount and not by the billed charges of the procedure on the claim.
2. Surgeries in the medical range (91000-99195) are normally not subject to the multiple surgery reductions.
3. The Medical Review Unit (MRU) will normally evaluate claims with
   • more than five surgical procedures during the same operative session; or
   • one or more unlisted procedures
   (Detailed operative reports may be required.)
4. Modifier 51 is used when multiple surgical procedures are performed and applies to the services of the surgeon only.

Multiple Surgery and Endoscopy Procedures
Unless state law requires otherwise, multiple endoscopy surgical procedures performed in the same operative session and are within the same base code family will be subject to multiple procedure reduction. The reduction percentage will vary by code family. The code ranges and percentages are as follows:

<table>
<thead>
<tr>
<th>Base Family</th>
<th>Codes</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder arthroscopy</td>
<td>29805 – 29826, 29827 – 29828</td>
<td>100% primary; 30% subsequent</td>
</tr>
<tr>
<td>Elbow arthroscopy</td>
<td>29830 – 29838</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Wrist arthroscopy</td>
<td>29840 – 29847</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Hip arthroscopy</td>
<td>29860 – 29863</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Knee arthroscopy</td>
<td>29870 – 29887</td>
<td>100% primary; 35% subsequent</td>
</tr>
<tr>
<td>Bronchoscopy</td>
<td>31622 – 31631, 31635 - 31636, 31638, 31640 – 31641, 31645</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Upper GI endoscopy</td>
<td>43231, 43232, 43235 – 43259</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>45378 – 45392</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Retrograde Cholangiopancreatography (ECRP)</td>
<td>43260 – 43265, 43267 – 43269, 43271 – 43272</td>
<td>100% primary; 25% subsequent</td>
</tr>
</tbody>
</table>

Other endoscopy code families and surgery procedures, not specified above, will be reimbursed based on multiple surgery reduction (MSR) policy of 100% for the primary and 50% for each payable subsequent procedure.

The primary surgery designation for all MSR will be based on the highest relative value based on CMS National Physician Fee Schedule Relative Value File.
Global Surgery Policy

- **Services/Supplies for Same Day Procedures.** Identifies service/supply codes that are not separately reimbursed when billed on the same day as surgery or procedure. These bundled services may include, but are not limited to:
  - Demonstration and/or evaluation of the use of an inhaler/nebulizer when performed with an evaluation and management service.
  - Interpretation and report of a routine EKG when performed with an E/M service.
  - Preventive medicine counseling when performed with a routine comprehensive preventive medical examination.

- **Unrelated E/M Services During the Post-op Period.** Services by the same physician, or a member of the physician’s group practice with the same tax ID number during the post-operative period, should be reported by appending modifier 24 to the E/M code. In addition to reporting modifier 24, the diagnosis code should be different than the diagnosis for the surgical service. A different diagnosis is defined when the first three digits of the diagnosis code differs from the first three digits of the diagnosis code reported for the surgical procedure.

- **Same Day Medical Visit.** ClaimsXten® identifies when an E/M visit is billed on the same day as a surgical procedure, substantial diagnostic or therapeutic procedure such as dialysis, chemotherapy and osteopathic manipulative treatment. An E/M code reported by the same provider on the same DOS is included within the global reimbursement for the procedure.

- **Pre-Op/Post-Op Rule. Pre and Post Operative Visit Editing.** Pre- and post-op evaluation and management (E/M) services by the same physician, or a member of the physician’s group practice with the same tax ID number, will be considered part of the surgical procedure reimbursement and will not be paid separately. When these services are rendered during the global surgical period as defined by CMS, ClaimsXten® will look across current and history claims to deny the E/M code if billed during the global surgical period.

CMS does not include all CPT codes in one of these three categories. Procedures that are not placed in these major categories are listed in supplemental categories of ‘MMM’, ‘XXX’, ‘YYY’, and ‘ZZZ’. 
Section 4 Billing/Claims Coding and Submission: UniCare PPO Illinois

Where CMS does not define global period, the following tables show examples of applicable postoperative days assigned by UniCare.

<table>
<thead>
<tr>
<th>MMM</th>
<th>“0” postoperative days except the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• “45” days for codes: 59400, 59410, 59510, 59515, 59610, 59614, 59618, and 59622.</td>
</tr>
<tr>
<td></td>
<td>• “10” days for codes: 59409, 59514, 59612, 59620 (These are “delivery” only codes.)</td>
</tr>
</tbody>
</table>

| XXX | “0” postoperative days |

| YYY | UniCare reserves the right to apply a global period for aftercare based on the postoperative days designated for a similar procedure. Please see new table below for YYY designations. |

| ZZZ | Same postoperative days as the parent procedure. For example: CPT 22585 will be assigned the same 90-day period as parent code 22554 |

YYY Designation Table:

<table>
<thead>
<tr>
<th>Applicable Postoperative Days</th>
<th>CPT Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>17999, 38589, 40899, 41899, 68899</td>
</tr>
<tr>
<td>45</td>
<td>59898</td>
</tr>
<tr>
<td></td>
<td>15999, 19499, 20999, 21089, 21299, 21499, 21899, 22899, 22999, 23929, 24999, 25999, 26989, 27299, 27599, 27899, 28899, 29999, 30999, 31299, 32999, 33999, 36299, 37501, 37799, 38129, 38999, 39499, 39599, 40799, 41599, 42299, 42699, 42999, 43656, 43999, 44238, 44799, 44899, 44979, 45499, 46999, 47379, 47399, 47579, 47999, 48999, 49329, 49659, 49999, 50549, 50949, 51999, 53899, 55559, 55899, 58578, 58679, 58999, 59899, 60659, 60699, 64999, 66999, 67299, 67599, 67999, 68399, 69399, 69799, 69949, 69979</td>
</tr>
</tbody>
</table>

Bilateral Billing. A bilateral procedure should be reported as a single line with the procedure code, one unit of service and modifier 50. If a bilateral procedure is submitted as two lines and one does not contain modifier 50, both line items will be denied and a new line item will be created with the code and modifier 50, and charges from both lines will be combined.
**Bundled Services/Supplies.** Identifies services and supplies that are considered part of overall care and are not separately reimbursed. Modifier 59 will not override this edit.

Following are inclusive procedure(s) and supply code(s) that are not reimbursed even if reported alone:

1. Administrative services requiring physician documentation (e.g. recertification, release forms, physical/camp/school/daycare forms, etc.)
2. All practice overhead costs, such as heat, light, safe access, regulatory compliance including CDC and OSHA compliance, general supplies (paper, gauze, band aids, etc.), insurance (including malpractice insurance), collections
3. Collection/analysis of digitally/computer stored data
4. Computer aided detection with chest radiography
5. Copies of test results for patient
6. Costs to perform participating provider agreement requirements, such as prior authorizations, appeals, notices of non-coverage
7. Determination of venous pressure
8. DME delivery and/or set up fees
9. Handling and/or conveyance fees
10. Heparin lock flush solution or kit for non therapeutic use
11. Insertion of a pain pump by the operating physician during a surgical procedure
12. Peak expiratory flow rate
13. Photography
14. Pharmacy dispensing services and/or supply fees, etc.
15. Physician care plan oversight
16. Post op follow up visit during the global period for reasons related to the original surgery
17. Prescriptions, electronic, fax or hard copy, new and renewal, including early renewal
18. Pulse oximetry
19. Recording or generation of automated data
20. Review of medical records
21. Robotic surgical system
22. Routine post surgical services such as dressing changes and suture removal
23. Supplemental tracking codes for performance measurement (Category II CPT Codes)
24. Surgical/procedural supplies and materials supplied by the provider rendering the primary service (e.g. surgical trays, syringes/needles, sterile water etc.)
25. Telephone consultations with the patient, family members, or other health care professionals
26. Team conferences to coordinate patient care
27. Handling or conveyance of laboratory specimens
Section 4 Billing/Claims Coding and Submission: UniCare PPO Illinois

The list below includes, but is not limited to, services that are not eligible for separate reimbursement when reported with another specific procedure or service.

1. Demonstration and/or evaluation of the use of an inhaler/nebulizer when performed with an evaluation and management service.
2. Interpretation and report of a routine EKG when performed with an evaluation and management service.
3. Preventive medicine counseling when performed with a routine comprehensive preventive medical examination.

Obstetrical Services

- **Global Delivery.** When a physician reports a routine maternity E/M or antepartum care service within 270 days of a global maternity delivery. If detected, the additional E/M and antepartum care services may be denied based on CPT coding guidelines governing what is included in the total obstetric package.
  - The global period does not include the initial office visit for diagnosis of pregnancy but includes all subsequent E/M visits reported with a normal pregnancy diagnosis. Global services are reimbursed according to a global fee.
  - Additional office visits for any unrelated condition or diagnosis code not within the range for normal pregnancy diagnosis are eligible for separate reimbursement.
  - A 45-day postpartum period applies for maternity delivery codes.

- **Multiple Vaginal Deliveries.** Should be billed with a global delivery code for the first delivery and a vaginal “delivery only” code for each additional birth. Additional deliveries are subject to the standard multiple surgical reimbursement policy:
  - Global delivery code: 100% of the maximum allowance.
  - Vaginal “delivery only” code, with modifier 59 appended: 50% of the maximum allowance.

- **Multiple C-Section Deliveries.** Only the global C-Section code will be reimbursed; no additional reimbursement is allowed for additional births when all babies are delivered by C-Section. Modifier 22 may be appended to the global or “delivery only” C-Section code if the physician work required for the multiple births is substantially greater than typically required. Documentation supporting the additional work must be submitted with the claim. “Additional work” includes, but is not limited to, increased intensity, time, technical difficulty of procedure and severity of patient’s condition.

- **Combined C-Section and Vaginal Multiple Deliveries**
  - Global vaginal delivery code for first delivery
  - C-Section “delivery only” code with modifier 59 appended for additional C-Section deliveries. Additional deliveries are subject to the standard multiple surgical reimbursement policy.
Laboratory Multi-code Rebulding. When codes that are part of a comprehensive multiple component blood test, described in the Laboratory section of CPT, are reported separately:

- Either the individual codes will be denied and the code representing the comprehensive procedure will be added to the claim for reimbursement; or
- The total eligible reimbursement for the separately reported codes will not exceed the maximum allowance for the single comprehensive code.

PAP Smear with E/M Code

Pap smear lab codes are not eligible for separate reimbursement when billed with E/M codes. In most cases when a family physician, internist or obstetrician/gynecologist submits a cytopathology/pap smear code, these are the physicians who obtained the specimen, not the pathologists preparing and/or interpreting the pap smear. The pathologist preparing and interpreting the cytopathology/pap smear must bill for this service separately.

The list below includes examples of pap smear codes that are to be reported by the pathologists, not by the physician who is obtaining the specimen.

- 88141 – 88155
- 88164 – 88167
- 88174 – 88175

Explanation of Benefits

UniCare maintains several claims payment systems An Explanation of Benefits (EOB) is issued upon claim finalization. EOBs are reimbursement reports that include detail line information and a summary of the payment.

The only charges for which the member may be billed are

- deductibles, co-payments and coinsurance amounts required by the member’s benefit agreement and
- medical services excluded by the member’s benefit agreement if the member has agreed in advance in writing to pay these charges.
Common Reasons for Rejected and Returned Claims
UniCare must sometimes return a claim for further information. Many of these returned claims result from incomplete or incorrect billing. Following are some of the more common reasons for returning a claim:

- **Date of injury not provided.** When charges represent an injury diagnosis, always provide a date of injury.
- **Duplicate billings.** Overlapping dates of service for the same service(s) will create a questionable duplicate bill.
- **ICD-9-CM codes denied.** Claims that are coded with a preliminary, rather than a definitive diagnosis, will be mailed back for the definitive diagnosis.
- **Medical records needed.** UniCare may require medical records before processing a claim. If medical records are required but are not submitted with the original claim, then a request form will be sent. **When sending the requested records to UniCare, attach the records to the original request form.** Do not reattach a new copy of the claim.

**NOTE:** Do not combine other request forms in the same envelope.

- **Unlisted HCPCS codes submitted without description.** When submitting claims electronically, enter the description in the REMARKS field.
- **Unreasonable numbers submitted.** Unreasonable numbers such as “9999” in the UNITS field.

Claims Appeals
A claim appeal is a formal written request from a provider for reconsideration of a claim already processed by UniCare. A written appeal for reconsideration of a denied claim or a claim the provider believes has been paid incorrectly should be submitted within 180 days from the date on the Explanation of Benefits along with a copy of the claim and any supporting documentation. Use the Claims Appeal Form or a detailed cover letter and mail to

UniCare
Attention: Appeals
PO Box 4458
Chicago, Illinois  60680

UniCare will provide a response within 60 days of receipt of the appeal.
Section 4 Billing/Claims Coding and Submission: UniCare PPO Mid-Atlantic (Maryland, Washington D.C.)

This section provides general billing guidelines and UniCare claim submission requirements that are effective as of 1/1/2004, including information about electronic claims submission. Reimbursement policy changes will be posted to the UniCare website, www.unicare.com. Your contract with UniCare requires that you keep all contract terms confidential, including the payment information provided with this disclosure. Should you have questions about this document, please telephone Network Services at 1-800-871-7888.

UniCare uses standard claim guidelines that are current as of the date of service. These guidelines have been developed in part using such references as the guidelines developed by the American Medical Association found in the Current Procedural Terminology (CPT) reference manual. UniCare reserves the right to change its guidelines from time to time without notice.

In the evaluation of claims, UniCare uses various sources including, but not limited to, the AMA position statements from its official publication “CPT assistant”, which is published monthly. The AMA also publishes other official publications such as “CPT changes” annually. Additional sources of information include Medicare Guidelines, updated quarterly, and specialty guidelines from sources such as the American College of Surgery, the Orthopedic Society, The American College of Cardiology and the American College of OB/GYN.

UniCare’s claim processing system incorporates edits based on coding guidelines mentioned above and other sources as well as analyses of medical and technological advances. In the event the claim is not submitted in accordance with UniCare medical policy and guidelines current at the time of service, UniCare may recode the claims as allowed under the UniCare participating Provider Agreements.

All claims submitted by the provider must use the medical services codes listed in the most current version of the AMA Current Procedural Terminology (CPT) and Health Care Procedure Coding system (HCPCS) publications. The provider must submit the medical services codes in accordance with the reporting guidelines and instructions contained in the AMA CPT, CPT Assistant and HCPCS publications.

Effective November 2009, the majority of UniCare’s business utilizes claim editing software called ClaimXten®, published by McKesson. The software includes ClaimCheck®, Clear Claim Connection™ and CMS National Correct Coding Initiative (NCCI) edits.

Updates to UniCare claims processing filters and edits, as a result of annual changes in these reporting guidelines and instructions, shall take place automatically and do not require any notice or disclosure to the provider or any contract amendment.

The presence of a code in published references does not indicate that payment by UniCare is available for the service. At UniCare’s discretion, payment structures are based on benefit plans and health care Provider Agreements.

This document is not intended to replace the provider manual, which contains additional information regarding credentialing, medical management and other issues not directly related to reimbursement. The provider manual is available on UniCare’s website at www.unicare.com.
Section 4 Billing/Claims Coding and Submission: UniCare PPO Mid-Atlantic (Maryland, Washington D.C.)

Electronic Claim Submission
UniCare supports claims submission via Electronic Data Interchange (“EDI”). Payor identification number 80314 is the only number needed to submit claims to UniCare.

UniCare receives submissions from independent third party software vendors, clearinghouses and billing services that collect data. EDI clearinghouses use an EDI network to connect to multiple payors. The EDI network routes communications between physicians and payors and automatically formats data into a standard UniCare format.

Listed below are UniCare approved clearinghouses for physician claims.

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availity</td>
<td><a href="http://www.availity.com">www.availity.com</a></td>
<td>(800) 282-4548</td>
</tr>
<tr>
<td>Cortex</td>
<td><a href="http://www.cortexedi.com">www.cortexedi.com</a></td>
<td>(800) 485-5977</td>
</tr>
<tr>
<td>CPSI</td>
<td><a href="http://www.cpsinet.com">www.cpsinet.com</a></td>
<td>(800) 711-3774</td>
</tr>
<tr>
<td>ENS</td>
<td><a href="http://www.enshealth.com">www.enshealth.com</a></td>
<td>(800) 341-6141</td>
</tr>
<tr>
<td>Emdeon Business Services</td>
<td><a href="http://www.emdeon.com">www.emdeon.com</a></td>
<td>(877) 363-3666</td>
</tr>
<tr>
<td>Gateway EDI</td>
<td><a href="http://www.gatewayedi.com">www.gatewayedi.com</a></td>
<td>(800) 969-3666</td>
</tr>
<tr>
<td>PayerPath</td>
<td><a href="http://www.payerpath.com">www.payerpath.com</a></td>
<td>(804) 560-2400</td>
</tr>
<tr>
<td>Per Se Technologies</td>
<td><a href="http://www.per-se.com">www.per-se.com</a></td>
<td>(847) 608-7000</td>
</tr>
<tr>
<td>MedAvant</td>
<td><a href="http://www.proxymed.com">www.proxymed.com</a></td>
<td>(714) 979-4467</td>
</tr>
<tr>
<td>SSI Group</td>
<td><a href="http://www.thessigroup.com">www.thessigroup.com</a></td>
<td>(800) 880-3032</td>
</tr>
</tbody>
</table>

Each of the above-named vendors is an independent entity not affiliated with UniCare or any of its affiliates, subsidiaries or parent corporation. Direct questions regarding electronic billing to UniCare EDI Services by phone at (877) 210-4083 or by email at ediunicare@wellpoint.com.

Useful EDI updates also appear on the UniCare web site, www.unicare.com

Paper Claim Submission
Providers who are not set up to submit claims electronically should submit paper claims on the CMS 1500 or equivalent claim form. Claims should be submitted to the address on the member’s identification card and should be accompanied by the preauthorization form if preauthorization of the service was required. If the member’s card is not available, call 1-800-UNICARE for assistance.

The following information is required:
- Member ID/Member HCID number
- Patient name
- Patient date of birth
- Valid ICD9/HCPCS/CPT codes
- Charge amount per line of expense
- Provider tax identification number
- NPI
- Provider address where service was rendered
- Provider license number*
Section 4 Billing/Claims Coding and Submission: UniCare PPO Mid-Atlantic (Maryland, Washington D.C.)

*Provider License Number/Professional License*
UniCare utilizes participating physicians’ and practitioners’ state license numbers as unique identifiers along with the zip code for the practice (i.e., the location where services are rendered). Professional claims submitted to UniCare that include this information are expedited. When using a tax identification number for a medical group (i.e., more than one physician bills under the same tax ID), always include the rendering physician’s or practitioner’s name and license number on the claim.

UniCare systems read the physician license number in Field 31 of the CMS 1500. Claims submitted without a state license number may be returned or their processing may be delayed.

Zip code of practice is required to determine claim payment for the following provider types:
- air ambulance
- blood bank
- donor bank
- ground ambulance
- independent laboratory
- medical vendor (e.g., DME, home health, dialysis)
- diagnostic imaging/MRI
- occupational therapy
- optician
- orthotics/prosthetics
- pharmacy
- portable x-ray/laboratory
- clinical laboratory

**Clinical Information**
Following is a list of claims categories that may routinely require submission of clinical information before or after payment of a claim. Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

10. Claims involving preauthorization/precertification or some other form of utilization review including but not limited to
   - claims pending for lack of preauthorization/precertification;
   - claims involving medical necessity or experimental/investigative determinations;
   - claims for pharmaceuticals requiring prior authorization.

11. Claims involving certain modifiers, including but not limited to Modifier 22.

12. Claims involving unlisted codes.

13. Claims for which we cannot determine from the face of the claim whether it involves a Covered Service; thus a benefit determination requires a medical record review, including but not limited to
   - pre-existing condition questions;
   - emergency service/prudent layperson reviews;
   - specific benefit exclusions.

14. Claims that may contain inappropriate billing.
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15. Claims that are the subject of an internal or external audit including high dollar claims.
16. Claims for individuals involved in case management or disease management programs.
17. Claims that have been appealed or that are otherwise the subject of a dispute, including claims in mediation, arbitration or litigation.
18. Other situations in which clinical information might routinely be requested:
   - requests relating to underwriting, including but not limited to member or physician misrepresentation/fraud reviews and stop loss coverage issues;
   - accreditation activities;
   - quality improvement/assurance activities;
   - credentialing;
   - coordination of benefits;
   - recovery/subrogation.

Site of Service
Providers whose agreements state that UniCare’s fee schedule is based upon the CMS RBRVS fee schedule must indicate the appropriate site of service on the claim so that UniCare may determine the correct allowable amount consistent with the current practice described by the CMS RBRVS fee schedule. Sites of service that will be reimbursed at the facility reimbursement rate include, but are not limited to, 21, 22, 23, 26, 31, 34, 41, 42, 51, 52, 53, and are subject to change in accordance with changes published by CMS, or its successor, in the Federal Register from time to time.

Claims Filing Deadlines
Physicians should submit claims to UniCare within 180 days after the later of
1. the date of service and
2. the date of the physician’s receipt of the EOB from the primary payor, when UniCare is the secondary payor.

UniCare shall extend the 180-day time period for a reasonable period, on a case by case basis, in the event that a physician provides notice to UniCare, along with appropriate evidence, of circumstances reasonably beyond the physician’s control that resulted in the delayed submission, as determined by UniCare.

Claims Authorizations
All services require the referral and authorization of the member’s Primary Care Physician. Some services also require benefit authorization by UniCare Medical Management. The claims system recognizes claims requiring benefit authorization based on the type of service rendered. When a claim requiring prior benefit authorization is identified, the system searches the medical management system for the corresponding authorization. The authorization notice is a document stating UniCare’s utilization management benefit determination of medical necessity based upon the member’s Benefit Agreement. If a benefit authorization is not found, retrospective medical necessity benefit determination may be made and the claim will be reviewed to determine if service was authorized by the Primary Care Physician. UniCare has published medical policies on UniCare’s website [www.unicare.com](http://www.unicare.com) Claims may be denied for failure to obtain benefit authorization when required. Call the Customer Service number on the member’s ID card to determine if service(s) require prior authorization.

Utilization management benefit determinations made by UniCare are solely for determination of whether the medical and/or hospital services meet the medical necessity criteria set forth in the member’s Benefit Agreement. Benefit authorization does not guarantee the payment of a claim.
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However, UniCare will not deny or reduce payment for pre-authorized services based on medical necessity or appropriateness of care unless the physician or provider has materially misrepresented the proposed medical or healthcare service or the physician or provider has substantially failed to perform the proposed medical or healthcare services. The responsibility for claim processing and payment determination rests solely with UniCare.

**Medical Necessity**

Medically necessary services are health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
3. not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

**Preauthorization Number**

Claims for the following services require submission of a UniCare preauthorization number. Additional medical record documentation may be required.

- Durable Medical Equipment (DME) rentals
- Durable Medical Equipment (DME) purchases exceeding $1000
- Infertility treatment
- Home infusion therapy

**Medical Records, Operative and Other Appropriate Reports**

Operative reports and records of the patient’s history may be required for claims for the following services:

- Blepharoplasty
- Breast reduction
- By-report surgeries
- Co-surgeon charges
- Cosmetic surgery
- CPT code ending in 999 (unlisted or by-report)
- Investigational surgery
- Multiple surgeries performed on the same date of service
- Obesity surgeries
- Rhinoplasty
- Septoplasty
Member Liability
The only charges for which the member may be liable and may be billed by a UniCare participating hospital, physician or practitioner are
1. deductibles, co-payments and co-insurance amounts required by the member’s Benefit Agreement, and
2. medical services not covered by the member’s Benefit Agreement where the member has agreed in advance in writing to assume financial responsibility. The member’s written agreement of financial responsibility must be specific to the services rendered.

UniCare plan designs may include a deductible that must be met before benefits are payable. Some plans may also have benefit-specific deductibles. The member is financially responsible for the deductible amount(s). In addition, the member is generally responsible for paying a co-payment or co-insurance for services received after all required deductibles have been satisfied. While co-payments and deductibles may be collected at the time the services are rendered, UniCare recommends billing the co-insurance amount upon receipt of the UniCare Explanation of Benefits.

To determine the member’s financial responsibility (i.e., his/her co-payment amount or whether s/he has satisfied any required deductible) contact the toll-free customer service number listed on the member’s identification card. This information is time-sensitive and subject to change upon adjudication of other claims.

Member Liability for Services Not Medically Necessary
Participating physicians and practitioners may not charge a member for medical services where benefits have been denied as not medically necessary under the terms of the Benefit Agreement unless the member has provided written agreement of financial responsibility in advance of receiving such services. The member’s written agreement of financial responsibility must be specific to the services rendered. If the amounts collected exceed the member’s responsibility, the physician or provider is required to issue a prompt refund once the EOB is received.

Coordination of Benefits
Coordination of Benefits (COB) determines responsibility for payment of eligible expenses among insurers providing insurance coverage to the member. When a member has more than one insurance coverage, primary and secondary coverages are normally determined in accordance with the Prime Carrier Rules or as required under the laws of the state in which the member’s Benefit Agreement was issued.

Prime Carrier Rules are often used by insurance carriers industry-wide and have been incorporated into appropriate UniCare benefit agreements. These rules determine the payment responsibilities between UniCare and other applicable group insurers by establishing which insurer is the prime carrier and which is the secondary carrier.

NOTE: The UniCare payment will not exceed the maximum allowable amount as determined in accordance with the UniCare fee schedule or as set for the in the Provider agreement, total charges or the member’s responsibility for Covered Services, whichever is less except as otherwise required by law.
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The Prime Carrier Rules normally do not apply to:
- non-group policies (individual policies)
- auto insurance policies
- Medicaid
- CHAMPUS/CHAMPVA

Third Party Liability
Third Party Liability (TPL) occurs when a person or entity other than the UniCare member may be liable or legally responsible for the member’s illness, injury or other condition and is, therefore, responsible for the costs associated with the member’s illness, injury or condition. UniCare may be entitled to reimbursement from the member from any settlement the member may receive in those situations.

IRS Backup Withholding
The Internal Revenue Service requires UniCare to withhold 30% in tax, called backup withholding if a payee does not furnish UniCare with the correct name and Taxpayer Identification Number combination as shown on the records of the Internal Revenue Service or Social Security Administration (“SSA”). “Payee” refers to all medical service providers.

Note: The withhold amount is 30% of the UniCare allowable amount, less any benefit reductions.

Generally, backup withholding begins when
1. A payee has been notified by UniCare that his/her name and/or tax ID does not match the name and/or tax ID on record with the IRS or SSA, and
2. The payee has not responded by submitting a completed and signed Form W-9 within thirty (30) business days from the date noted on the solicitation.

Providers who receive this solicitation should complete the Form W-9 and promptly mail it to

UniCare Corporate Tax Department
1831 Chestnut Street
St. Louis, MO 63103

NOTE: Any amounts withheld under the federal tax rules discussed above may not be charged to or reimbursed from the member.

Please direct questions to UniCare’s Tax Department at (888) 246-4893.
Section 4 Billing/Claims Coding and Submission: UniCare PPO Mid-Atlantic (Maryland, Washington D.C.)

Overpayment and Recovery Procedures
In the event of an overpayment, UniCare seeks recovery of all excess claim payments from the payee to whom the UniCare check was made payable. The procedure for recovery of overpayments involves multiple notifications to payee and allows an opportunity for appeal.

Overpayment Recovery Process
The initial notice regarding overpayment recovery will be provided not later than the 365th day from the original claim payment date; however, active collection efforts will not begin until 30 days after notification of overpayment. The overpayment and recovery process follows:

Day 1 – Overpayment is identified.

Day 3 – 1st Letter is sent, notifying payee of identification of overpayment and that UniCare will begin recovery process through offset of future claims payments or other recovery methods, if the refund is not received by XX/XX/XX (equal to 60th day from day 1). The letter will include the specific claim at issue and amounts for which a refund is due, the basis and specific reasons for the refund request, and a notice of appeal rights.

Day 30 – 2nd Letter is sent to payee requesting overpayment refund, informing payee that UniCare will begin recovery process through offset of future claims payments or other recovery methods if the refund is not received by XX/XX/XX (equal to 60th day from day 1). The letter will include the contact information for UniCare, the specific claim at issue and amounts for which a refund is due, the basis and specific reasons for the refund request, and a notice of appeal rights.

Day 60 – 3rd Letter is sent to payee as a reminder of the overpayment refund due to UniCare. The letter will include the contact information for UniCare, the specific claim at issue and amounts for which a refund is due, the basis and specific reasons for the refund request, and a notice of appeal rights. UniCare will begin to offset future claims payments or internal collection methods, including, but not limited to, referral to collection vendor if the payee has not made arrangements for payment of the refund and has not requested an appeal.

Day 90 – 4th Letter is sent to payee advising that UniCare will refer the overpayment to external collections if payment is not received within 10 days from the date of this letter. The letter will include the contact information for UniCare, the specific claim at issue and amounts for which a refund is due, the basis and specific reasons for the refund request and a notice of appeal rights.

In some situations, UniCare determines that recovery of an overpayment through future claims payments is not feasible, in which case the overpayment may be referred to an external collection agency or handled internally in an effort to recover.

Refund of Overpayment
Overpayment refund checks should be made out to UniCare and mailed to:

UniCare Cost Containment and Overpayment Avoidance (C COA)
P.O. BOX 5019
Bolingbrook, IL 60440

Include the following information when submitting an overpayment refund:

- Copy of the claim Explanation of Benefits statement, sent from UniCare
- Refund amount and reason for the overpayment refund
Section 4 Billing/Claims Coding and Submission: UniCare PPO Mid-Atlantic (Maryland, Washington D.C.)

If the Explanation of Benefits statement is not included, provide the following identifying information:

- Name of patient
- Patient’s date of birth
- UniCare subscriber identification number
- UniCare claim number
- Date of service
- Name and address of provider
- Provider Tax ID Number
- Amount originally billed
- Amount of original claim payment
- Refund amount
- Reason for the overpayment refund
- Name and telephone number of sender, in case we need additional information related to the refund

Telephone UniCare Cost Containment and Overpayment Avoidance (CCOA) between the hours of 8:00 AM to 4:00 PM Monday – Thursday, 8:00 AM to 3:00 PM Friday, Central Standard Time at 866-297-2764 or in writing at:

UniCare Cost Containment and Overpayment Avoidance (CCOA)
P.O. BOX 5019
Bolingbrook, IL 60440

Overpayment Appeal Process
In the event of an overpayment, UniCare seeks recovery of all excess claim payments from the payee to whom the UniCare check was made payable. The procedure for recovery of overpayments includes multiple notifications to payee and allows an opportunity for appeal.

If the payee disagrees with the request for overpayment refund, an appeal should be sent within 45 days of first date of notification of overpayment for consideration. All collection efforts, including offsets of future payments are pended until the appeal process is completed.

Appeals can be requested by telephone between the hours of 8:00 AM to 4:00 PM Monday – Thursday, 8:00 AM to 3:00 PM Friday, Central Standard Time at 866-297-2764 or in writing at:

UniCare Cost Containment and Overpayment Avoidance
P.O. Box 5019
Bolingbrook, IL 60440

Split Year Claims
Two claims are required for services that begin before December 31 but extend beyond the end of the calendar year: one claim for services incurred through December 31 and a second claim for services beginning January 1. This is necessary to track calendar year deductibles and co-payment maximums.
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Fee Schedule, Reimbursement, Coding and Bundling Guidelines
As outlined in the Provider Agreement, once a claim is determined to be payable, the maximum allowable rate is the fee schedule associated with each code or such other payment arrangement specified in the Agreement. Conversion factors and unit values are not included. Provider-specific fee schedules may be provided on paper, CD-Rom or diskette on request.

In the evaluation of claims, UniCare uses various sources including, but not limited to, the AMA position statements from its official publication, “CPT assistant”, which is published monthly. The AMA also publishes other official publications such as “CPT changes” annually. Additional sources of information include Medicare Guidelines, updated quarterly, and specialty guidelines from sources such as the American College of Surgery, the Orthopedic Society, The American College of Cardiology and the American College of OB/GYN.

The claim processing system utilized by UniCare incorporates edits based on coding guidelines mentioned above and other sources as well as analyses of medical and technological advances. In the event the claim is not submitted in accordance with UniCare medical policy and guidelines current at the time of service, UniCare may recode the claims as allowed under the UniCare participating provider agreements.

NOTE: Inclusion of a procedure in the CPT codebook does not imply UniCare coverage or reimbursement.

UniCare uses these guidelines for administrative purposes such as claims processing and the development of guidelines for medical review and medical policy. For hospital claims UniCare generally uses Milliman USA guidelines along with UniCare’s own medical policies, which are published on www.unicare.com.

Effective 1/1/2009, UniCare modified its reimbursement methodology. The revised methodology provides a standardized UniCare proprietary fee schedule that is not tied to the CMS fee schedule.

Provider Agreements will include one of two rate exhibits
1. Prevailing Exhibit: 100% of the market prevailing fee schedule as determined by UniCare
2. Carveout: Variation to the Prevailing Rate determined by negotiating rates acceptable to UniCare
   - Carveout codes are limited in both number and variation to the market prevailing rate as established or approved by UniCare
   - Only carveout codes receive additional reimbursement; remaining codes are paid at the prevailing rate.

Modifications to the proprietary fee schedule that result in material adverse changes will be communicated to providers 90 days prior to the change effective date. Proprietary fee schedules will be evaluated annually.

Following are general UniCare claims submission and reimbursement guidelines.
Section 4 Billing/Claims Coding and Submission: UniCare PPO Mid-Atlantic (Maryland, Washington D.C.)

System Edits
Claim system edits are in place for claims processing and are generally based on CPT Coding Guidelines unless otherwise indicated. Claims not submitted in accordance with CPT Coding Guidelines cannot be readily processed and are subject to return or rejection. Some claims may be subject to UniCare medical review. The Medical Review Unit may review the claim and medical records to ensure accurate billing. In the event the claim is not submitted in accordance with UniCare medical policy and coding guidelines current at the time of service, UniCare may recode the claim as allowed under the UniCare participating provider agreement.

Edit Descriptions
An Incidental Procedure is performed at the same time as a more complex primary procedure. The incidental procedure does not require significant additional physician resources and/or is clinically integral to the performance of the primary procedure.

Mutually Exclusive Procedures are two or more procedures usually not performed during the same patient encounter on the same date of service. Mutually exclusive rules may also govern different procedure code descriptions for the same type of procedure for which the physician should be submitting only one procedure.

Procedure Re Bundling occurs when two or more procedures are used to describe a service when a single, more comprehensive procedure exists that more accurately describes the complete service performed by a Provider. In this instance the two codes may be replaced with the more appropriate code.

Base Code Quantity. Identifies a claim reporting a primary service with a base code that has a quantity greater than one, rather than reporting the appropriate add-on code. The line item with the base code quantity greater than one will be denied and replaced with a line item that allows payment for only one procedure. This edit also identifies multiple occurrences of a base code on separate lines and the additional base code line items will be denied. (See CPT Appendix D for list of add-on codes.)

Add-on Code Without Base Code. Identifies situations where an add-on code has been billed without the related primary service/procedure (base code). According to the CPT manual, “Add-on codes are always performed in addition to the primary service/procedure (base code), and must never be reported as a stand-alone code.” If an add-on code is submitted without the base code, it will be denied. Therefore, it is important that the add-on code and base code be submitted on the same claim. In addition, if the base code is not eligible for reimbursement, the add-on code will also be denied.

New Patient Evaluation and Management (E/M). Identifies new patient E/M codes billed for established patients. According to the AMA, “A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the last three years.” When detected, the new patient E/M code will be denied.
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**HCPCS and CPT Codes**
Current HCPCS and CPT manuals must be used, since many changes are made to these codes annually. These manuals may be purchased at any technical book store or by writing to

Book and Pamphlet Fulfillment OP-3411/8
American Medical Association
P.O. Box 10946
Chicago, IL 60610-0926, or by calling

HCPCS: (800) 633-7467
AMA/CPT: (800) 621-8335

**Unlisted Procedure or Service.** There may be services or procedures performed by physicians that are not found in the CPT codebook. Specific code numbers have been designated for reporting unlisted procedures.

A description of the service should always accompany a bill for an unlisted procedure code. This information will expedite claim processing. UniCare’s Medical Review Unit will review these services. Medical record review may also be required to determine benefits for an unlisted procedure or service.

**Reimbursement for HCPCS Level II Codes**
- **Durable Medical Equipment, Supplies (including, but not limited to, infusion therapy supplies), Prosthetics and Orthotics.** The maximum allowable amount will normally be based on whether the equipment is new, used or rented as identified by the HCPCS Level II Code Modifier. UniCare may designate certain items as “rental only” or “purchase only” or “rent to purchase.” For “rent to purchase” items, the maximum allowable is the UniCare-determined purchase price; rental will not exceed the purchase price. Codes not identified by a modifier as “purchase” will be considered rentals.

- **Other HCPCS Codes.** The maximum allowable reimbursement is based on UniCare-selected published market data, including but not limited to sources such as the Drug Topics Red Book, Medispan and First Databank and are reviewed annually. Self-injectable drugs for home use and all oral prescription drugs dispensed in the physician’s office will be denied as not payable and the physician may not bill the member. These services must be provided by a licensed UniCare network pharmacy for the member to obtain the maximum benefit under the pharmacy benefit plan.

**Note:** UniCare does not compensate for hot and cold packs when billed on the same date of service as other codes.
Section 4 Billing/Claims Coding and Submission: UniCare PPO Mid-Atlantic (Maryland, Washington D.C.)

CPT Codes Not Eligible for Payment include, but are not limited to the following:

CPT Code A4649 Surgical Supply; miscellaneous.
CPT Code 36000 Introduction of needle or intra-catheter, vein.
CPT Code 99051 Services provided in the office during regularly scheduled evening, weekend or holiday office hours in addition to basic service.
CPT Code 99053 Services provided between 10pm and 8am at 24-hour facility, in addition to basic service.
CPT Code 99056 Services typically provided in the office, provided out of the office at request of patient, in addition to basic service.
CPT Code 99058 Services provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service.
CPT Code 99060 Services provided on an emergency basis, out of the office, which disrupt other scheduled office services, in addition to basic service.
CPT Code 99070 Supplies and materials provided by the physician over and above those usually included with the office visit or other services. Providers should use HCPCS Level II codes, which give a detailed description of the service provided.
CPT Code 99080 Special reports such as insurance forms or more than the information conveyed in the usual medical communications or standard reporting forms.

Prolonged Physician Services

CPT Codes 99354-99355 Prolonged physician service in the office or other outpatient setting requiring direct face-to-face patient contact beyond the usual service. (E.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting.)

The face-to-face Prolonged Services codes were designed to separate direct physician services from time spent coordinating patient care, prior to or following a patient encounter. However, UniCare does not reimburse prolonged service codes when used to designate time spent counseling the patient during the performance of an E/M service.

Prolonged services are expected to be reported and may be eligible for separate reimbursement in a few acute or unique situations:

- An example of an acute situation may be respiratory distress with shortness of breath or severe wheezing, or a severe allergic reaction with systemic pruritus or swelling. Physician treatment in this case may require significant additional physician time to monitor response to treatment provided beyond what is typically included in an E/M or other reported services.
- In addition, there may be a unique situation which may require hours of direct face-to-face physician involvement for which there is no other appropriate CPT code to report.
- CPT codes 99354-99355 may be eligible for separate reimbursement when the E/M service performed and reported is based on the required component factors (which are history, exam, and decision making, but not counseling or coordination of care) and is not based on time, and:
  - The standard office record clearly documents the content of the specific face-to-face physician service provided, beyond what is typically included in the E/M service
  - Start and stop times are noted and are at least 30 minutes or more beyond the typical time of the reported E/M. Anything less than 30 minutes is considered part of the work effort of the base E/M.
  - For additional 30 minute increments, documented service and time frames need to be at least 15 minutes or more to be reported.
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CPT Codes 99356-99357 Prolonged physician service in the inpatient setting requiring unit/floor time beyond the usual service.

CPT Codes 99358-99359 Prolonged evaluation and management service before and/or after direct face-to-face patient care. (E.g., review of extensive records and tests, communication with other professionals and/or the patient/family.)

Modifiers
A modifier indicates that the procedure performed by the physician has been altered by some specific circumstance but has not changed in its definition or code. The presence of a modifier in the current CPT, HCPCS or other procedure manuals does not necessarily indicate that the service is payable by UniCare. UniCare retains discretion in the determination of payment structures.

Modifiers may be billed in accordance with the CPT and HCPCS manual to indicate the following:

- A service or procedure requiring a professional or technical component. (Not all services are considered to have professional or technical components; some procedures are considered professional only or global only.)
- A service or procedure performed by more than one physician and/or in more than one location.
- A service or procedure that increased or was reduced.
- A service or procedure rendered more than once.
- Partial procedure performed.
- Adjunctive services.
- Bilateral procedures.
- Unusual events occurred.

Following are the most commonly used modifiers.

**Modifier 22 Increased Procedural Services:** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. This code will be pended for medical review if medical records are attached, processed without review if records are not attached. Additional allowance will be made on a case-by-case basis when supported in medical documentation (allowance +20%).

**Modifier 24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period:** The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. Certain bundling edits will be overridden when billed according to AMA/CPT guidelines. In addition to reporting modifier 24, the diagnosis should be different from the diagnosis for the surgical period. A different diagnosis occurs when the first three digits of the two diagnoses differ. Supporting documentation is not required with claim submission, but may be requested.

**Modifier 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service:** This modifier can be submitted with Evaluation and Management services and with ophthalmology examinations and evaluation services. UniCare generally will recognize modifier 25, for payment purposes, when modifier 25 is appropriately reported from both a clinical and coding perspective.
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Modifier 26 Clinical Pathology Codes: Certain procedure codes when used in conjunction with a modifier describe either one or a combination of a physician component and a technical component of a service. When reporting the physician component of a code only, Modifier 26 should be used. When reporting with clinical pathology codes, no payment will be made except for select codes that require a separately identifiable professional interpretation beyond the technical component. The list of pathology codes for which Modifier 26 may be payable may change from time to time and is based in part of CMS guidelines.

Services billed without a modifier 26 are considered to be global services. Cardiac catheterization services should be billed with Modifier 26 to reflect the professional component.

Modifier 50 Bilateral Procedure: The maximum allowable rate for the surgical service may be increased by up to 50% for the bilateral procedure unless the service is otherwise identified as a single code.

Modifier 51 Multiple Procedures: Multiple Surgical Reduction rule (100%, 50%, 50% of maximum allowable rate) is normally applied to claims for multiple procedures performed at the same operative session. See Multiple Surgeries section following.

Modifier 52 Reduced Service: A 50% reduction will be applied to any reimbursement for services associated with this code. If these services are provided in conjunction with other surgical procedures, the standard approach to reimbursement for multiple surgeries will also apply.

Modifier 53 Discontinued Procedure: A 50% reduction will be applied to any reimbursement for procedures associated with this code. If these procedures are provided in conjunction with other surgical procedures, the standard approach to reimbursement for multiple surgeries will also apply.

Modifier 54 Surgical Care Only: Claim determination is normally based upon 70% of maximum allowable rate of the surgical procedure.

Modifier 55 Postoperative Management: When billed with a surgical CPT code claim determination is normally based upon 30% of the maximum allowable rate of the surgical procedure. If billed with an office visit code, there is no value change.

Modifier 56 Preoperative Management: When billed with a surgical CPT code claim determination is normally based upon 10% of the maximum allowable rate of the surgical procedure.

Modifier 62 Co-surgeons: Claim determination is normally based upon 125% of maximum allowable rate and 50% is normally allowed to each surgeon.

Modifier 63 Procedure Performed on Infants less than 4 kg: Claim determination is normally based upon 120% of maximum allowable rate.

Modifiers 73, 74 Discontinued Outpatient Hospital/Ambulatory Surgery Center Procedure Prior to/After Administration of Anesthesia: No reimbursement, since code is inappropriate for professional provider billing.

Modifier 78 Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period: Claim determination is normally based upon 70% of maximum allowable rate.

Modifiers 80, 81, 82 Assistant Surgeon: Claim determination is normally based upon 16% of the maximum allowable rate of the surgical procedure.
Modifier 99 Multiple Modifiers: All claims billed with this modifier are subject to medical review.

Modifier AS Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist services for assistant at surgery: Claim determination is normally based upon 14% of the maximum allowable rate.

Duplicate Professional and Technical Components
This rule considers component procedures (professional or technical) a duplicate if the global procedure is billed by the same provider for the same member on the same date of service. This edit is based on CMS coding guidelines; procedures with a “PCTC Ind” indicator in the National Physician Fee Schedule Relative Value File are included in this list of procedures.

Technical Only or Complete Service for Hospital Inpatient or Outpatient
No reimbursement. Physicians who provide clinical lab, pathology, radiology or other diagnostic testing services to hospital inpatients or outpatients shall only be reimbursed for the professional component fee allowance (when the code has a separate professional component RVU assigned based on CMS guidelines). There will be no reimbursement to the physician for the technical component only, or the complete service. Such reimbursement has been included in the payment to the hospital.

Anesthesia Modifiers QK, QX Medical Direction Claim determination is normally based upon 50% of the allowable rate.

Anesthesia
Rendering a patient insensible to pain during surgical, obstetrical and certain other medically necessary procedures caused by the administration of a drug or by other medical interventions.

General anesthesia. A state of unconsciousness with the absence of pain and/or sensation, produced by anesthesia agents that affect the entire body. Drugs that produce this state are administered intravenously, rectally, intramuscularly or by inhalation.

Regional anesthesia. The absence of pain and/or sensation produced by introducing an agent that interrupts the sensory nerve conduction to a specific area (region) of the body.

- **Field block:** Introduction of a local or topical anesthetic to produce the absence of pain and/or sensation to an operative area of the body.
  - Local anesthesia may be used in more than one area of the body. Any agent used to produce the absence of pain and/or sensation other than to the entire body is a local anesthetic.
  - Topical anesthesia includes local agents applied to the surface in areas such as eyes and mucous membranes where injections are not recommended or possible. Eye drops, creams and sprays are common topical agents.
- **Nerve block:** Introduction of an anesthetic agent close to a nerve so that conduction is cut off. Spinal and caudal anesthesia are types of nerve blocks into the spinal column. These types of anesthesia are often desired for abdominal or obstetrical surgery and affect a large area of the body.
Policy
Charges for anesthesia administration may be eligible for contract benefits when
1. provided by a physician, typically an anesthesiologist (MD, DO) or a Certified Registered Nurse Anesthetist (CRNA); and
2. performed in conjunction with a covered surgical, medical, obstetric or radiology service.

Anesthesia Services Most Often Eligible for Payment
- Services of an anesthesiologist or CRNA billed by a hospital on UB-92 are considered ancillary services and reimbursed according to the terms of the hospital agreement.
- Anesthesia, given in conjunction with a covered surgical or obstetrical procedure, where the anesthesiologist or CRNA is in constant attendance with the patient administering anesthesia, monitoring and managing life functions, managing unconsciousness, and/or managing fluid therapy (regardless of where the surgery is performed). Such care includes pre-anesthetic evaluation, intra-anesthetic record keeping and post-anesthetic follow-up.
- Anesthesia services for continuous epidural on obstetrical procedures requires the following information:
  1. Type of anesthesia (epidural, lumbar or caudal, or spinal)
  2. Start and stop time of labor anesthesia
  3. Start and stop time of delivery anesthesia
  4. Type of delivery performed
- Anesthesia, given in conjunction with certain covered non-surgical procedures, when the procedure requires that the patient be kept absolutely still or is too painful to be performed without anesthesia as identified with either a modifier code or a procedure code.
- Anesthesia services identified as qualifying circumstances (by the use of additional CPT codes 99100, 99116, 99135 and 99140).
- Anesthesia with Medical Direction (QK, QX, QY) will allow for allocation of payment between supervising Anesthesiologists and CRNA(s).
- Anesthesia physical status modifiers P1 and P2. (Modifiers P3 – P6 are normally eligible for payment in accordance with ASA guidelines.)

Anesthesia Services Often Not Eligible for Payment
- Anesthesia given in conjunction with a non-covered surgery or non-covered medical procedure.
- Field block local anesthesia administered by the surgeon who performed the surgery. Field block local anesthesia is included in the surgery value; however, the cost of the materials for the local (e.g., anesthetic agent) is eligible for benefits.
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- The usual preoperative and postoperative visits, anesthesia care during the procedure, administration of fluids and/or blood and the usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry).

  **Exception:** The following unusual forms of monitoring are not included in the price of anesthesia and may be payable in addition to the anesthesia services:
  
  - intra-arterial, CPT 36620
  - Swan-Ganz, CPT 93503

- Anesthesia services billed by the same provider (surgeon, radiologist or endoscopist) performing the procedure requiring the anesthesia.

**Special Circumstances**

- **Pain management.** Intravenous administration of drugs, where a machine controls the dosage and duration.
  
  - Patient Controlled Analgesia (PCA). UniCare often allows the initial consultation or set-up. If subsequent visits are billed, claims are subject to medical review for determination of medical necessity in accordance with the criteria in the Benefit Agreement.
  
  - Continuous Epidural (non Obstetric). This is extremely rare and usually billed for hospice care end term and is subject to Medical Review for benefit determination.

- **Nerve Block.** Administered by a surgeon, and performed by injection for the purpose of anesthesia or therapeutic pain control.
  
  A nerve block procedure billed either with an anesthesia CPT or the nerve block procedure code with Modifier 30 or Modifier AA through AG performed in conjunction with a surgical procedure is considered anesthesia services. UniCare normally reimburses anesthesia using the base anesthesia unit value only. Time units are not allowed. Nerve block procedures not billed as anesthesia services are considered therapeutic and reimbursed as surgery.

  **Exception:** Obstetrical claims billed with a nerve block CPT procedure code may be reimbursed as anesthesia.

- **Standby during Percutaneous Transluminal Coronary Angioplasty (PTCA)**

- **Hypnosis.** When used as anesthesia during surgery is subject to medical review.

- **Acupuncture.** Billed as an anesthesia service.

- **Unusual anesthesia.** Billed with Modifier 23. Indicates unusual circumstances. Documentation must be provided to support the unusual circumstances and will be subject to medical review for benefit determination.

**Special Notes**

- When two or more anesthesia procedures are billed during the same operative session, the anesthesia allowable amount will be determined by the procedure with the greater anesthesia units plus time units.

- If a second procedure begins more than one hour after the anesthesia end time of the first procedure, both procedures are considered separate operative sessions and the base and time units of each procedure normally are considered separately.
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Obstetrical Anesthesia
The time for continuous lumbar epidural, caudal or spinal injection anesthesia when used during
labor and delivery (01967) is calculated at one unit for every hour or fraction (e.g., 01-60 minutes
equals one unit; 61-120 minutes equals two units, 121-180 minutes equals three units, etc.).
There is no differentiation between continuous epidurals for vaginal and cesarean deliveries. If a
scheduled vaginal delivery subsequently results in a cesarean delivery, codes 01967 and 01968
must be billed.

Anesthesia Allowance
The allowable amount for anesthesia services is normally determined by multiplying the sum of
the base units for the service and the time units expended by the appropriate conversion factor.
Anesthesia time units are normally calculated in units of 15 minutes (in increments of 5 minutes
unless noted otherwise).

Anesthesia Time
Anesthesia time units are calculated in units of 15 minutes unless noted otherwise. Total number
of minutes must be included on all anesthesia claims in field 24G of the CMS 1500.

Anesthesia Codes and Modifiers
UniCare requires current CPT codes 00100 – 01999 for anesthesia administration claims. (CPT
codes 00100 – 01999 identify the section of the body where the procedure was performed, not the
type of procedure performed.) UniCare does not allow the practice of billing anesthesia services
using surgical codes with a modifier. In addition, when two or more surgical procedures are
performed during the same operative session, only the anesthesia procedure with the higher base
unit value is allowed for reimbursement.

Multiple Surgeries
Multiple surgery claims are normally priced based on major and minor procedures performed on the
same date of service during the same surgical session. The surgical procedure with the highest
UniCare unit value is considered the major procedure and is priced at 100 percent of the unit value.
The minor surgeries have a lesser unit value and are normally reduced as follows:

- **Incidental Surgery.** A surgical procedure that is performed as part of another surgery and should
  not be billed separately (commonly referred to as ‘unbundling’). The charge for the incidental
  procedure is included in the provider’s write-off.

4. **‘As Is’ Surgeries.** Surgeries outside the Integumentary System (CPT range 10040-19499) that
   are always subsequent procedures (e.g., additional segment, suture of additional nerve). These
   surgeries are always billed with another surgery and never billed as stand-alone procedures.

5. **Bilateral Surgery.** Surgeries performed through separate incisions to matching parts of the body
   (e.g., both shoulders). These surgeries are identified either with the surgical procedure and
   modifier 50, or the surgical procedure billed twice with modifier 50 attached to the second
   procedure.

6. **Block Procedures.** Surgeries in the Integumentary System that consist of a parent code and
   subsequent procedures, which merely increase the complexity of the parent procedure. The
   entire ‘block’ is considered one surgery.
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Additional Information
1. Major and minor surgeries are priced line-by-line based on the UniCare allowed amount and not by the billed charges of the procedure on the claim.
2. Surgeries in the medical range (91000-99195) are normally not subject to the multiple surgery reductions.
3. The Medical Review Unit (MRU) will normally evaluate claims with more than five surgical procedures during the same operative session; or
4. one or more unlisted procedures

(Detailed operative reports may be required.)
Modifier 51 is used when multiple surgical procedures are performed and applies to the services of the surgeon only.

Multiple Surgery and Endoscopy Procedures
Unless state law requires otherwise, multiple endoscopy surgical procedures performed in the same operative session and are within the same base code family will be subject to multiple procedure reduction. The reduction percentage will vary by code family. The code ranges and percentages are as follows:

<table>
<thead>
<tr>
<th>Base Family</th>
<th>Codes</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder arthroscopy</td>
<td>29805 – 29826, 29827 – 29828</td>
<td>100% primary; 30% subsequent</td>
</tr>
<tr>
<td>Elbow arthroscopy</td>
<td>29830 – 29838</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Wrist arthroscopy</td>
<td>29840 – 29847</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Hip arthroscopy</td>
<td>29860 – 29863</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Knee arthroscopy</td>
<td>29870 – 29887</td>
<td>100% primary; 35% subsequent</td>
</tr>
<tr>
<td>Bronchoscopy</td>
<td>31622 – 31631, 31635 - 31636, 31638, 31640 – 31641, 31645</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Upper GI endoscopy</td>
<td>43231, 43232, 43235 – 43259</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>45378 – 45392</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Retrograde Cholangiopancreatography (ECRP)</td>
<td>43260 – 43265, 43267 – 43269, 43271 – 43272</td>
<td>100% primary; 25% subsequent</td>
</tr>
</tbody>
</table>

Other endoscopy code families and surgery procedures, not specified above, will be reimbursed based on multiple surgery reduction (MSR) policy of 100% for the primary and 50% for each payable subsequent procedure.

The primary surgery designation for all MSR will be based on the highest relative value based on CMS National Physician Fee Schedule Relative Value File.
Global Surgery Policy

- **Services/Supplies for Same Day Procedures.** Identifies service/supply codes that are not separately reimbursed when billed on the same day as surgery or procedure. These bundled services may include, but are not limited to:
  - Demonstration and/or evaluation of the use of an inhaler/nebulizer when performed with an evaluation and management service.
  - Interpretation and report of a routine EKG when performed with an E/M service.
  - Preventive medicine counseling when performed with a routine comprehensive preventive medical examination.

- **Unrelated E/M Services During the Post-op Period.** Services by the same physician, or a member of the physician’s group practice with the same tax ID number during the post-operative period, should be reported by appending modifier 24 to the E/M code. In addition to reporting modifier 24, the diagnosis code should be different than the diagnosis for the surgical service. A different diagnosis is defined when the first three digits of the diagnosis code differs from the first three digits of the diagnosis code reported for the surgical procedure.

- **Same Day Medical Visit.** ClaimsXten® identifies when an E/M visit is billed on the same day as a surgical procedure, substantial diagnostic or therapeutic procedure such as dialysis, chemotherapy and osteopathic manipulative treatment. An E/M code reported by the same provider on the same DOS is included within the global reimbursement for the procedure.

- **Pre-Op/Post-Op Rule. Pre and Post Operative Visit Editing.** Pre- and post-op evaluation and management (E/M) services by the same physician, or a member of the physician’s group practice with the same tax ID number, will be considered part of the surgical procedure reimbursement and will not be paid separately. When these services are rendered during the global surgical period as defined by CMS, ClaimsXten® will look across current and history claims to deny the E/M code if billed during the global surgical period.

CMS does not include all CPT codes in one of these three categories. Procedures that are not placed in these major categories are listed in supplemental categories of ‘MMM’, ‘XXX’, ‘YYY’, and ‘ZZZ’.
Section 4 Billing/Claims Coding and Submission: UniCare PPO Mid-Atlantic (Maryland, Washington D.C.)

Where CMS does not define global period, the following tables show examples of applicable postoperative days assigned by UniCare.

<table>
<thead>
<tr>
<th>MMM</th>
<th>“0” postoperative days except the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• “45” days for codes: 59400, 59410, 59510, 59515, 59610, 59614, 59618, and 59622.</td>
</tr>
<tr>
<td></td>
<td>• “10” days for codes: 59409, 59514, 59612, 59620 (These are “delivery” only codes.)</td>
</tr>
</tbody>
</table>

| XXX | “0” postoperative days |

| YYY | UniCare reserves the right to apply a global period for aftercare based on the postoperative days designated for a similar procedure. Please see new table below for YYY designations. |

| ZZZ | Same postoperative days as the parent procedure. For example: CPT 22585 will be assigned the same 90-day period as parent code 22554 |

### YYY Designation Table:

<table>
<thead>
<tr>
<th>Applicable Postoperative Days</th>
<th>CPT Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>17999, 38589, 40899, 41899, 68899</td>
</tr>
<tr>
<td>45</td>
<td>59898</td>
</tr>
<tr>
<td></td>
<td>15999, 19499, 20999, 21089, 21299, 21499, 21899, 22899, 22999, 23929, 24999, 25999, 26989, 27299, 27599, 27899, 28899, 29999, 30999, 31299, 32999, 33999, 36299, 37501, 37799, 38129, 38999, 39499, 39599, 40799, 41599, 42299, 42699, 42999, 43656, 43999, 44238, 44799, 44899, 44979, 45499, 46999, 47379, 47399, 47579, 47999, 48999, 49329, 49659, 49999, 50549, 50949, 51999, 53899, 55559, 55899, 58578, 58679, 58999, 59899, 60659, 60699, 64999, 66999, 67299, 67599, 67999, 68399, 69399, 69799, 69949, 69979</td>
</tr>
</tbody>
</table>

**Bilateral Billing.** A bilateral procedure should be reported as a single line with the procedure code, one unit of service and modifier 50. If a bilateral procedure is submitted as two lines and one does not contain modifier 50, both line items will be denied and a new line item will be created with the code and modifier 50, and charges from both lines will be combined.
Section 4 Billing/Claims Coding and Submission: UniCare PPO Mid-Atlantic (Maryland, Washington D.C.)

Bundled Services/Supplies. Identifies services and supplies that are considered part of overall care and are not separately reimbursed. Modifier 59 will not override this edit.

Following are inclusive procedure(s) and supply code(s) that are not reimbursed even if reported alone:

1. Administrative services requiring physician documentation (e.g. recertification, release forms, physical/camp/school/daycare forms, etc.)
2. All practice overhead costs, such as heat, light, safe access, regulatory compliance including CDC and OSHA compliance, general supplies (paper, gauze, band aids, etc.), insurance (including malpractice insurance), collections
3. Collection/analysis of digitally/computer stored data
4. Computer aided detection with chest radiography
5. Copies of test results for patient
6. Costs to perform participating provider agreement requirements, such as prior authorizations, appeals, notices of non-coverage
7. Determination of venous pressure
8. DME delivery and/or set up fees
9. Handling and/or conveyance fees
10. Heparin lock flush solution or kit for non therapeutic use
11. Insertion of a pain pump by the operating physician during a surgical procedure
12. Peak expiratory flow rate
13. Photography
14. Pharmacy dispensing services and/or supply fees, etc.
15. Physician care plan oversight
16. Post op follow up visit during the global period for reasons related to the original surgery
17. Prescriptions, electronic, fax or hard copy, new and renewal, including early renewal
18. Pulse oximetry
19. Recording or generation of automated data
20. Review of medical records
21. Robotic surgical system
22. Routine post surgical services such as dressing changes and suture removal
23. Supplemental tracking codes for performance measurement (Category II CPT Codes)
24. Surgical/procedural supplies and materials supplied by the provider rendering the primary service (e.g. surgical trays, syringes/needles, sterile water etc.)
25. Telephone consultations with the patient, family members, or other health care professionals
26. Team conferences to coordinate patient care
27. Handling or conveyance of laboratory specimens
Section 4 Billing/Claims Coding and Submission: UniCare PPO Mid-Atlantic
(Maryland, Washington D.C.)

The list below includes, but is not limited to, services that are not eligible for separate reimbursement when reported with another specific procedure or service.

1. Demonstration and/or evaluation of the use of an inhaler/nebulizer when performed with an evaluation and management service.
2. Interpretation and report of a routine EKG when performed with an evaluation and management service.
3. Preventive medicine counseling when performed with a routine comprehensive preventive medical examination.

Obstetrical Services
- **Global Delivery.** When a physician reports a routine maternity E/M or antepartum care service within 270 days of a global maternity delivery. If detected, the additional E/M and antepartum care services may be denied based on CPT coding guidelines governing what is included in the total obstetric package.
  - The global period does not include the initial office visit for diagnosis of pregnancy but includes all subsequent E/M visits reported with a normal pregnancy diagnosis. Global services are reimbursed according to a global fee.
  - Additional office visits for any unrelated condition or diagnosis code not within the range for normal pregnancy diagnosis are eligible for separate reimbursement.
  - A 45-day postpartum period applies for maternity delivery codes.

- **Multiple Vaginal Deliveries.** Should be billed with a global delivery code for the first delivery and a vaginal “delivery only” code for each additional birth. Additional deliveries are subject to the standard multiple surgical reimbursement policy:
  - Global delivery code: 100% of the maximum allowance.
  - Vaginal “delivery only” code, with modifier 59 appended: 50% of the maximum allowance.

- **Multiple C-Section Deliveries.** Only the global C-Section code will be reimbursed; no additional reimbursement is allowed for additional births when all babies are delivered by C-Section. Modifier 22 may be appended to the global or “delivery only” C-Section code if the physician work required for the multiple births is substantially greater than typically required. Documentation supporting the additional work must be submitted with the claim. “Additional work” includes, but is not limited to, increased intensity, time, technical difficulty of procedure and severity of patient’s condition.

- **Combined C-Section and Vaginal Multiple Deliveries**
  - Global vaginal delivery code for first delivery
  - C-Section “delivery only” code with modifier 59 appended for additional C-Section deliveries. Additional deliveries are subject to the standard multiple surgical reimbursement policy.
Laboratory Multi-code Rebundling. When codes that are part of a comprehensive multiple component blood test, described in the Laboratory section of CPT, are reported separately:
- Either the individual codes will be denied and the code representing the comprehensive procedure will be added to the claim for reimbursement; or
- The total eligible reimbursement for the separately reported codes will not exceed the maximum allowance for the single comprehensive code.

PAP Smear with E/M Code
Pap smear lab codes are not eligible for separate reimbursement when billed with E/M codes. In most cases when a family physician, internist or obstetrician/gynecologist submits a cytopathology/pap smear code, these are the physicians who obtained the specimen, not the pathologists preparing and/or interpreting the pap smear. The pathologist preparing and interpreting the cytopathology/pap smear must bill for this service separately.

The list below includes examples of pap smear codes that are to be reported by the pathologists, not by the physician who is obtaining the specimen.
- 88141 – 88155
- 88164 – 88167
- 88174 – 88175

Explanation of Benefits
UniCare maintains several claims payment systems. An Explanation of Benefits (EOB) is issued upon claim finalization. EOBs are reimbursement reports that include detail line information and a summary of the payment.

The only charges for which the member may be billed are
- deductibles, co-payments and coinsurance amounts required by the member’s benefit agreement and
- medical services excluded by the member’s benefit agreement if the member has agreed in advance in writing to pay these charges.
Common Reasons for Rejected and Returned Claims
UniCare must sometimes return a claim for further information. Many of these returned claims result from incomplete or incorrect billing. Following are some of the more common reasons for returning a claim:

- **Date of injury not provided.** When charges represent an injury diagnosis, always provide a date of injury.
- **Duplicate billings.** Overlapping dates of service for the same service(s) will create a questionable duplicate bill.
- **ICD-9-CM codes denied.** Claims that are coded with a preliminary, rather than a definitive diagnosis, will be mailed back for the definitive diagnosis.
- **Medical records needed.** UniCare may require medical records before processing a claim. If medical records are required but are not submitted with the original claim, then a request form will be sent. **When sending the requested records to UniCare, attach the records to the original request form.** Do not reattach a new copy of the claim.
- **NOTE:** Do not combine other request forms in the same envelope.
- **Unlisted HCPCS codes submitted without description.** When submitting claims electronically, enter the description in the REMARKS field.
- **Unreasonable numbers submitted.** Unreasonable numbers such as “9999” in the UNITS field.

Claims Appeals
A claim appeal is a formal written request from a provider for reconsideration of a claim already processed by UniCare. A written appeal for reconsideration of a denied claim or a claim the provider believes has been paid incorrectly should be submitted within 180 days from the date on the Explanation of Benefits along with a copy of the claim and any supporting documentation. Use the Claims Appeal Form or a detailed cover letter and mail to

UniCare
Attention: Appeals
PO Box 4458
Chicago, Illinois  60680

UniCare will provide a response within 60 days of receipt of the appeal.
Section 4 Billing/Claims Coding and Submission: UniCare PPO Texas

This section provides general billing guidelines and UniCare claim submission requirements that are effective as of 1/1/2004, including information about electronic claims submission. Reimbursement policy changes will be posted to the UniCare website, www.unicare.com. Your contract with UniCare requires that you keep all contract terms confidential, including the payment information provided with this disclosure. Should you have questions about this document, please telephone Network Services at 1-888-697-3790 (Houston) or 1-888-697-3791 (Plano).

UniCare uses standard claim guidelines that are current as of the date of service. These guidelines have been developed in part using such references as the guidelines developed by the American Medical Association found in the Current Procedural Terminology (CPT) reference manual. UniCare reserves the right to change its guidelines from time to time without notice.

In the evaluation of claims, UniCare uses various sources including, but not limited to, the AMA position statements from its official publication “CPT assistant”, which is published monthly. The AMA also publishes other official publications such as “CPT changes” annually. Additional sources of information include Medicare Guidelines, updated quarterly, and specialty guidelines from sources such as the American College of Surgery, the Orthopedic Society, The American College of Cardiology and the American College of OB/GYN.

UniCare’s claim processing system incorporates edits based on coding guidelines mentioned above and other sources as well as analyses of medical and technological advances. In the event the claim is not submitted in accordance with UniCare medical policy and guidelines current at the time of service, UniCare may recode the claims as allowed under the UniCare participating Provider Agreements.

All claims submitted by the provider must use the medical services codes listed in the most current version of the AMA Current Procedural Terminology (CPT) and Health Care Procedure Coding system (HCPCS) publications. The provider must submit the medical services codes in accordance with the reporting guidelines and instructions contained in the AMA CPT, CPT Assistant and HCPCS publications.

Effective November 2009, the majority of UniCare’s business utilizes claim editing software called ClaimXten®, published by McKesson. The software includes ClaimCheck®, Clear Claim Connection™ and CMS National Correct Coding Initiative (NCCI) edits.

Updates to UniCare claims processing filters and edits, as a result of annual changes in these reporting guidelines and instructions, shall take place automatically and do not require any notice or disclosure to the provider or any contract amendment.

The presence of a code in published references does not indicate that payment by UniCare is available for the service. At UniCare’s discretion, payment structures are based on benefit plans and health care Provider Agreements.

This document is not intended to replace the provider manual, which contains additional information regarding credentialing, medical management and other issues not directly related to reimbursement. The provider manual is available on UniCare’s website at www.unicare.com.
Electronic Claim Submission
UniCare supports claims submission via Electronic Data Interchange (“EDI”). Payor identification number **80314** is the only number needed to submit claims to UniCare.

UniCare receives submissions from independent third party software vendors, clearinghouses and billing services that collect data. EDI clearinghouses use an EDI network to connect to multiple payors. The EDI network routes communications between physicians and payors and automatically formats data into a standard UniCare format.

Listed below are UniCare approved clearinghouses for physician claims.

<table>
<thead>
<tr>
<th>Clearinghouse</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availity</td>
<td><a href="http://www.availity.com">www.availity.com</a></td>
<td>(800) 282-4548</td>
</tr>
<tr>
<td>Cortex</td>
<td><a href="http://www.cortexedi.com">www.cortexedi.com</a></td>
<td>(800) 485-5977</td>
</tr>
<tr>
<td>CPSI</td>
<td><a href="http://www.cpsinet.com">www.cpsinet.com</a></td>
<td>(800) 711-3774</td>
</tr>
<tr>
<td>ENS</td>
<td><a href="http://www.enshealth.com">www.enshealth.com</a></td>
<td>(800) 341-6141</td>
</tr>
<tr>
<td>Emdeon Business Services</td>
<td><a href="http://www.emdeon.com">www.emdeon.com</a></td>
<td>(877) 363-3666</td>
</tr>
<tr>
<td>Gateway EDI</td>
<td><a href="http://www.gateawayedi.com">www.gateawayedi.com</a></td>
<td>(800) 969-3666</td>
</tr>
<tr>
<td>PayerPath</td>
<td><a href="http://www.payerpath.com">www.payerpath.com</a></td>
<td>(804) 560-2400</td>
</tr>
<tr>
<td>Per Se Technologies</td>
<td><a href="http://www.per-se.com">www.per-se.com</a></td>
<td>(847) 608-7000</td>
</tr>
<tr>
<td>MedAvant</td>
<td><a href="http://www.proxymed.com">www.proxymed.com</a></td>
<td>(714) 979-4467</td>
</tr>
<tr>
<td>SSI Group</td>
<td><a href="http://www.thessigroup.com">www.thessigroup.com</a></td>
<td>(800) 880-3032</td>
</tr>
</tbody>
</table>

Each of the above-named vendors is an independent entity not affiliated with UniCare or any of its affiliates, subsidiaries or parent corporation. Direct questions regarding electronic billing to UniCare EDI Services by phone at (877) 210-4083 or by email at ediunicare@wellpoint.com.

Useful EDI updates also appear on the UniCare web site, **www.unicare.com**

Paper Claim Submission
Providers who are not set up to submit claims electronically should submit paper claims on the CMS 1500 or equivalent claim form. Claims should be submitted to the address on the member’s identification card and should be accompanied by the precertification form if precertification of the service was required. If the member’s card is not available, call 1-800-UNICARE for assistance.

The following information is required:
- Member ID/Members HCID number
- Patient name
- Patient date of birth
- Valid ICD9/HCPCS/CPT codes
- Charge amount per line of expense
- Provider tax identification number
- NPI
- Provider address where service was rendered
- Provider license number*
Section 4 Billing/Claims Coding and Submission: UniCare PPO Texas

*Provider License Number/Professional License*
UniCare utilizes participating physicians’ and practitioners’ state license numbers as unique identifiers along with the zip code for the practice (i.e., the location where services are rendered). Professional claims submitted to UniCare that include this information are expedited. When using a tax identification number for a medical group (i.e., more than one physician bills under the same tax ID), always include the rendering physician’s or practitioner’s name and license number on the claim.

UniCare systems read the physician license number in Field 31 of the CMS 1500. Claims submitted without a state license number may be returned or their processing may be delayed.

Zip code of practice is required to determine claim payment for the following provider types:
- air ambulance
- blood bank
- donor bank
- ground ambulance
- independent laboratory
- medical vendor (e.g., DME, home health, dialysis)
- diagnostic imaging/MRI
- occupational therapy
- optician
- orthotics/prosthetics
- pharmacy
- portable x-ray/laboratory
- clinical laboratory

Clinical Information
Following is a list of claims categories that may routinely require submission of clinical information before or after payment of a claim. Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

1. Claims involving prior authorization/precertification or some other form of utilization review including but not limited to
2. claims pending for lack of prior authorization/precertification;
3. claims involving medical necessity or experimental/investigative determinations;
4. claims for pharmaceuticals requiring prior authorization.
5. Claims involving certain modifiers, including but not limited to Modifier 22.
6. Claims involving unlisted codes.
7. Claims for which we cannot determine from the face of the claim whether it involves a Covered Service; thus a benefit determination requires a medical record review, including but not limited to
8. pre-existing condition questions;
9. emergency service/prudent layperson reviews;
10. specific benefit exclusions.
11. Claims that may contain inappropriate billing.
12. Claims that are the subject of an internal or external audit including high dollar claims.
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13. Claims for individuals involved in case management or disease management programs.

14. Claims that have been appealed or that are otherwise the subject of a dispute, including claims in mediation, arbitration or litigation.

15. Other situations in which clinical information might routinely be requested:
   - requests relating to underwriting, including but not limited to member or physician misrepresentation/fraud reviews and stop loss coverage issues;
   - accreditation activities;
   - quality improvement/assurance activities;
   - credentialing;
   - coordination of benefits;
   - recovery/subrogation.

Site of Service

Providers whose agreements state that UniCare’s fee schedule is based upon the CMS RBRVS fee schedule must indicate the appropriate site of service on the claim so that UniCare may determine the correct allowable amount consistent with the current practice described by the CMS RBRVS fee schedule. Sites of service that will be reimbursed at the facility reimbursement rate include, but are not limited to, 21, 22, 23, 26, 31, 34, 41, 42, 51, 52, 53, and are subject to change in accordance with changes published by CMS, or its successor, in the Federal Register from time to time.

Claims Filing Deadlines

Physicians should submit claims to UniCare within 180 days after the later of
1. the date of service and
2. the date of the physician’s receipt of the EOB from the primary payor, when UniCare is the secondary payor.

UniCare shall extend the 180-day time period for a reasonable period, on a case by case basis, in the event that a physician provides notice to UniCare, along with appropriate evidence, of circumstances reasonably beyond the physician’s control that resulted in the delayed submission, as determined by UniCare.

Claims Authorizations

The claims system recognizes claims requiring benefit authorization based on the type of service rendered. When a claim requiring prior benefit authorization is identified, the system searches the medical management system for the corresponding authorization. The prior authorization notice is a document stating UniCare’s utilization management benefit determination of medical necessity based upon the member’s Certificate of Coverage. If a prior authorization is not found, the claim may be reviewed retrospectively for medical necessity. UniCare has published medical policies on UniCare’s website www.unicare.com Claims may be denied for failure to obtain benefit authorization when required. Call the Customer Service number on the member’s ID card to determine if service(s) require prior authorization.

Utilization management benefit determinations made by UniCare are solely for determination of whether the medical and/or hospital services meet the medical necessity criteria set forth in the member’s Benefit Agreement. Benefit authorization does not guarantee the payment of a claim. However, UniCare will not deny or reduce payment for pre-authorized services based on medical necessity or appropriateness of care unless the physician or provider has materially misrepresented the proposed medical or healthcare service or the physician or provider has substantially failed to perform the proposed medical or healthcare services. The responsibility for claim processing and payment determination rests solely with UniCare.
Medical Necessity
Medically necessary services are health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are
1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
3. not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Prior authorization Number
Claims for the following services require submission of a UniCare prior authorization number. Additional medical record documentation may be required.
- Durable Medical Equipment (DME) rentals
- Durable Medical Equipment (DME) purchases exceeding $1000
- Infertility treatment
- Home infusion therapy
Medical Records, Operative and Other Appropriate Reports
Operative reports and records of the patient’s history may be required for claims for the following services:

- Blepharoplasty
- Breast reduction
- By-report surgeries
- Co-surgeon charges
- Cosmetic surgery
- CPT code ending in 999 (unlisted or by-report)
- Investigational surgery
- Multiple surgeries performed on the same date of service
- Obesity surgeries
- Rhinoplasty
- Septoplasty

Member Liability
The only charges for which the member may be liable and may be billed by a UniCare participating hospital, physician or practitioner are

1. deductibles, co-payments and co-insurance amounts required by the member’s Benefit Agreement, and
2. medical services not covered by the member’s Benefit Agreement where the member has agreed in advance in writing to assume financial responsibility. The member’s written agreement of financial responsibility must be specific to the services rendered.

UniCare plan designs may include a deductible that must be met before benefits are payable. Some plans may also have benefit-specific deductibles. The member is financially responsible for the deductible amount(s). In addition, the member is generally responsible for paying a co-payment or co-insurance for services received after all required deductibles have been satisfied. While co-payments and deductibles may be collected at the time the services are rendered, UniCare recommends billing the co-insurance amount upon receipt of the UniCare Explanation of Benefits.

To determine the member’s financial responsibility (i.e., his/her co-payment amount or whether s/he has satisfied any required deductible) contact the toll-free customer service number listed on the member’s identification card. This information is time-sensitive and subject to change upon adjudication of other claims.

Member Liability for Services Not Medically Necessary
Participating physicians and practitioners may not charge a member for medical services where benefits have been denied as not medically necessary under the terms of the Benefit Agreement unless the member has provided written agreement of financial responsibility in advance of receiving such services. The member’s written agreement of financial responsibility must be specific to the services rendered. If the amounts collected exceed the member’s responsibility, the physician or provider is required to issue a prompt refund once the EOB is received.
Coordination of Benefits
Coordination of Benefits (COB) determines responsibility for payment of eligible expenses among insurers providing insurance coverage to the member. When a member has more than one insurance coverage, primary and secondary coverages are normally determined in accordance with the Prime Carrier Rules or as required under the laws of the state in which the member’s Benefit Agreement was issued.

Prime Carrier Rules are often used by insurance carriers industry-wide and have been incorporated into appropriate UniCare benefit agreements. These rules determine the payment responsibilities between UniCare and other applicable group insurers by establishing which insurer is the prime carrier and which is the secondary carrier.

NOTE: The UniCare payment will not exceed the maximum allowable amount as determined in accordance with the UniCare fee schedule or as set for the in the Provider Agreement, total charges or the member’s responsibility for Covered Services, whichever is less except as otherwise required by law.

The Prime Carrier Rules normally do not apply to:
- non-group policies (individual policies)
- auto insurance policies
- Medicaid
- CHAMPUS/CHAMPVA

Third Party Liability
Third Party Liability (TPL) occurs when a person or entity other than the UniCare member may be liable or legally responsible for the member’s illness, injury or other condition and is, therefore, responsible for the costs associated with the member’s illness, injury or condition. UniCare may be entitled to reimbursement from the member from any settlement the member may receive in those situations.

IRS Backup Withholding
The Internal Revenue Service requires UniCare to withhold 30% in tax, called backup withholding, if a payee does not furnish UniCare with the correct name and Taxpayer Identification Number combination as shown on the records of the Internal Revenue Service or Social Security Administration (“SSA”). “Payee” refers to all medical service providers.

Note: The withhold amount is 30% of the UniCare allowable amount, less any benefit reductions.

Generally, backup withholding begins when
1. A payee has been notified by UniCare that his/her name and/or tax ID does not match the name and/or tax ID on record with the IRS or SSA, and
2. The payee has not responded by submitting a completed and signed Form W-9 within thirty (30) business days from the date noted on the solicitation.

Providers who receive this solicitation should complete the Form W-9 and promptly mail it to

UniCare Corporate Tax Department
1831 Chestnut Street
St. Louis, MO 63103

NOTE: Any amounts withheld under the federal tax rules discussed above may not be charged to or reimbursed from the member.

Please direct questions to UniCare’s Tax Department at (888) 246-4893.
Section 4 Billing/Claims Coding and Submission: UniCare PPO Texas

Overpayment and Recovery Procedures
In the event of an overpayment, UniCare seeks recovery of all excess claim payments from the payee to whom the UniCare check was made payable. The procedure for recovery of overpayments involves multiple notifications to payee and allows an opportunity for appeal.

Overpayment Recovery Process
The initial notice regarding overpayment recovery will be provided not later than the 365th day from the original claim payment date; however, active collection efforts will not begin until 30 days after notification of overpayment. The overpayment and recovery process follows:

Day 1 – Overpayment is identified.

Day 3 – 1st Letter is sent, notifying payee of identification of overpayment and that UniCare will begin recovery process through offset of future claims payments or other recovery methods, if the refund is not received by XX/XX/XX (equal to 60th day from day 1). The letter will include the specific claim at issue and amounts for which a refund is due, the basis and specific reasons for the refund request, and a notice of appeal rights.

Day 30 – 2nd Letter is sent to payee requesting overpayment refund, informing payee that UniCare will begin recovery process through offset of future claims payments or other recovery methods if the refund is not received by XX/XX/XX (equal to 60th day from day 1). The letter will include the contact information for UniCare, the specific claim at issue and amounts for which a refund is due, the basis and specific reasons for the refund request, and a notice of appeal rights.

Day 60 – 3rd Letter is sent to payee as a reminder of the overpayment refund due to UniCare. The letter will include the contact information for UniCare, the specific claim at issue and amounts for which a refund is due, the basis and specific reasons for the refund request, and a notice of appeal rights. UniCare will begin to offset future claims payments or internal collection methods, including, but not limited to, referral to collection vendor if the payee has not made arrangements for payment of the refund and has not requested an appeal.

Day 90 – 4th Letter is sent to payee advising that UniCare will refer the overpayment to external collections if payment is not received within 10 days from the date of this letter. The letter will include the contact information for UniCare, the specific claim at issue and amounts for which a refund is due, the basis and specific reasons for the refund request and a notice of appeal rights.

In some situations, UniCare determines that recovery of an overpayment through future claims payments is not feasible, in which case the overpayment may be referred to an external collection agency or handled internally in an effort to recover.

Refund of Overpayment
Overpayment refund checks should be made payable to UniCare and mailed to:

UniCare Cost Containment and Overpayment Avoidance (CCOA)
P.O. BOX 5019
Bolingbrook, IL 60440

Include the following information when submitting an overpayment refund:
- Copy of the claim Explanation of Benefits statement, sent from UniCare
- Refund amount and reason for the overpayment refund

If the Explanation of Benefits statement is not included, provide the following identifying information:
- Name of patient
- Patient’s date of birth
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- UniCare subscriber identification number
- UniCare claim number
- Date of service
- Name and address of provider
- Provider Tax ID Number
- Amount originally billed
- Amount of original claim payment
- Refund amount
- Reason for the overpayment refund
- Name and telephone number of sender, in case we need additional information related to the refund

Telephone UniCare Cost Containment and Overpayment Avoidance (CCOA) between the hours of 8:00 AM to 4:00 PM Monday – Thursday, 8:00 AM to 3:00 PM Friday, Central Standard Time at 866-297-2764 or in writing at:

UniCare Cost Containment and Overpayment Avoidance (CCOA)
P.O. BOX 5019
Bolingbrook, IL 60440

Overpayment Appeal Process
In the event of an overpayment, UniCare seeks recovery of all excess claim payments from the payee to whom the UniCare check was made payable. The procedure for recovery of overpayments includes multiple notifications to payee and allows an opportunity for appeal.

If the payee disagrees with the request for overpayment refund, an appeal should be sent within 45 days of first date of notification of overpayment for consideration. All collection efforts, including offsets of future payments are pended until the appeal process is completed.

Appeals can be requested by telephone between the hours of 8:00 AM to 4:00 PM Monday – Thursday, 8:00 AM to 3:00 PM Friday, Central Standard Time at 866-297-2764 or in writing at:

UniCare Cost Containment and Overpayment Avoidance (CCOA)
P.O. BOX 5019
Bolingbrook, IL 60440

Split Year Claims
Two claims are required for services that begin before December 31 but extend beyond the end of the calendar year: one claim for services incurred through December 31 and a second claim for services beginning January 1. This is necessary to track calendar year deductibles and co-payment maximums.

Fee Schedule, Reimbursement, Coding and Bundling Guidelines
As outlined in the Provider Agreement, once a claim is determined to be payable, the maximum allowable rate is the fee schedule associated with each code or such other payment arrangement specified in the Agreement. Conversion factors and unit values are not included. Provider-specific fee schedules may be provided on paper, CD-Rom or diskette on request.

UniCare uses these guidelines for administrative purposes such as claims processing and the development of guidelines for medical review and medical policy. Following are some general UniCare claims submission and reimbursement guidelines.
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System Edits
Claim system edits are in place for claims processing and are generally based on CPT Coding Guidelines unless otherwise indicated. Claims not submitted in accordance with CPT Coding Guidelines cannot be readily processed and are subject to return or rejection. Some claims may be subject to UniCare medical review. The Medical Review Unit may review the claim and medical records to ensure accurate billing. In the event the claim is not submitted in accordance with UniCare medical policy and coding guidelines current at the time of service, UniCare may recode the claim as allowed under the UniCare participating provider agreement.

Edit Descriptions
An Incidental Procedure is performed at the same time as a more complex primary procedure. The incidental procedure does not require significant additional physician resources and/or is clinically integral to the performance of the primary procedure.

Mutually Exclusive Procedures are two or more procedures usually not performed during the same patient encounter on the same date of service. Mutually exclusive rules may also govern different procedure code descriptions for the same type of procedure for which the physician should be submitting only one procedure.

Procedure Rebundling occurs when two or more procedures are used to describe a service when a single, more comprehensive procedure exists that more accurately describes the complete service performed by a Provider. In this instance the two codes may be replaced with the more appropriate code.

Base Code Quantity. Identifies a claim reporting a primary service with a base code that has a quantity greater than one, rather than reporting the appropriate add-on code. The line item with the base code quantity greater than one will be denied and replaced with a line item that allows payment for only one procedure. This edit also identifies multiple occurrences of a base code on separate lines and the additional base code line items will be denied. (See CPT Appendix D for list of add-on codes.)

Add-on Code Without Base Code. Identifies situations where an add-on code has been billed without the related primary service/procedure (base code). According to the CPT manual, “Add-on codes are always performed in addition to the primary service/procedure (base code), and must never be reported as a stand-alone code.” If an add-on code is submitted without the base code, it will be denied. Therefore, it is important that the add-on code and base code be submitted on the same claim. In addition, if the base code is not eligible for reimbursement, the add-on code will also be denied.

New Patient Evaluation and Management (E/M). Identifies new patient E/M codes billed for established patients. According to the AMA, “A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the last three years.” When detected, the new patient E/M code will be denied.

HCPCS and CPT Codes
Current HCPCS and CPT manuals must be used, since many changes are made to these codes annually. These manuals may be purchased at any technical book store or by writing to

Book and Pamphlet Fulfillment OP-3411/8
American Medical Association
P.O. Box 10946
Chicago, IL 60610-0926, or by calling

HCPCS: (800) 633-7467
AMA/CPT: (800) 621-8335
Unlisted Procedure or Service. There may be services or procedures performed by physicians that are not found in the CPT codebook. Specific code numbers have been designated for reporting unlisted procedures.

A description of the service should always accompany a bill for an unlisted procedure code. This information will expedite claim processing. UniCare’s Medical Review Unit will review these services. Medical record review may also be required to determine benefits for an unlisted procedure or service.

Reimbursement for HCPCS Level II Codes

- **Durable Medical Equipment, Supplies (including, but not limited to, infusion therapy supplies), Prosthetics and Orthotics.** The maximum allowable amount will normally be based on whether the equipment is new, used or rented as identified by the HCPCS Level II Code Modifier. UniCare may designate certain items as “rental only” or “purchase only” or “rent to purchase.” For “rent to purchase” items, the maximum allowable is the UniCare-determined purchase price; rental will not exceed the purchase price. Codes not identified by a modifier as “purchase” will be considered rentals.

- **Other HCPCS Codes.** The maximum allowable reimbursement is based on UniCare-selected published market data, including but not limited to sources such as the Drug Topics Red Book, Medispan and First Databank and are reviewed annually. Self-injectable drugs for home use and all oral prescription drugs dispensed in the physician’s office will be denied as not payable and the physician may not bill the member. These services must be provided by a licensed UniCare network pharmacy for the member to obtain the maximum benefit under the pharmacy benefit plan.

**Note:** UniCare does not compensate for hot and cold packs when billed on the same date of service as other codes.
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CPT Codes Not Eligible for Payment include, but are not limited to the following:

CPT Code A4649 Surgical Supply; miscellaneous.
CPT Code 36000 Introduction of needle or intra-catheter, vein.
CPT Code 99051 Services provided in the office during regularly scheduled evening, weekend or holiday office hours in addition to basic service.
CPT Code 99053 Services provided between 10pm and 8am at 24-hour facility, in addition to basic service.
CPT Code 99056 Services typically provided in the office, provided out of the office at request of patient, in addition to basic service.
CPT Code 99058 Services provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service.
CPT Code 99060 Services provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service.
CPT Code 99070 Supplies and materials provided by the physician over and above those usually included with the office visit or other services. Providers should use HCPCS Level II codes, which give a detailed description of the service provided.
CPT Code 99080 Special reports such as insurance forms or more than the information conveyed in the usual medical communications or standard reporting forms.

Prolonged Physician Services

CPT Codes 99354-99355 Prolonged physician service in the office or other outpatient setting requiring direct face-to-face patient contact beyond the usual service. (E.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting.)

The face-to-face Prolonged Services codes were designed to separate direct physician services from time spent coordinating patient care, prior to or following a patient encounter. However, UniCare does not reimburse prolonged service codes when used to designate time spent counseling the patient during the performance of an E/M service.

Prolonged services are expected to be reported and may be eligible for separate reimbursement in a few acute or unique situations:

- An example of an acute situation may be respiratory distress with shortness of breath or severe wheezing, or a severe allergic reaction with systemic pruitus or swelling. Physician treatment in this case may require significant additional physician time to monitor response to treatment provided beyond what is typically included in an E/M or other reported services.
- In addition, there may be a unique situation which may require hours of direct face-to-face physician involvement for which there is no other appropriate CPT code to report.
- CPT codes 99354-99355 may be eligible for separate reimbursement when the E/M service performed and reported is based on the required component factors (which are history, exam, and decision making, but not counseling or coordination of care) and is not based on time, and:
  - The standard office record clearly documents the content of the specific face-to-face physician service provided, beyond what is typically included in the E/M service
  - Start and stop times are noted and are at least 30 minutes or more beyond the typical time of the reported E/M. Anything less than 30 minutes is considered part of the work effort of the base E/M.
  - For additional 30 minute increments, documented service and time frames need to be at least 15 minutes or more to be reported.
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CPT Codes 99356-99357 Prolonged physician service in the inpatient setting requiring unit/floor time beyond the usual service.

CPT Codes 99358-99359 Prolonged evaluation and management service before and/or after direct face-to-face patient care. (E.g., review of extensive records and tests, communication with other professionals and/or the patient/family.)

Modifiers
A modifier indicates that the procedure performed by the physician has been altered by some specific circumstance but has not changed in its definition or code. The presence of a modifier in the current CPT, HCPCS or other procedure manuals does not necessarily indicate that the service is payable by UniCare. UniCare retains discretion in the determination of payment structures.

Modifiers may be billed in accordance with the CPT and HCPCS manual to indicate the following:

- A service or procedure requiring a professional or technical component. (Not all services are considered to have professional or technical components; some procedures are considered professional only or global only.)
- A service or procedure performed by more than one physician and/or in more than one location.
- A service or procedure that increased or was reduced.
- A service or procedure rendered more than once.
- Partial procedure performed.
- Adjunctive services.
- Bilateral procedures.
- Unusual events occurred.

Following are the most commonly used modifiers.

**Modifier 22 Increased Procedural Services:** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. This code will be pended for medical review if medical records are attached, processed without review if records are not attached. Additional allowance will be made on a case-by-case basis when supported in medical documentation (allowance +20%).

**Modifier 24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period:** The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. Certain bundling edits will be overridden when billed according to AMA/CPT guidelines. In addition to reporting modifier 24, the diagnosis should be different from the diagnosis for the surgical period. A different diagnosis occurs when the first three digits of the two diagnoses differ. Supporting documentation is not required with claim submission, but may be requested.

**Modifier 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service:** This modifier can be submitted with Evaluation and Management services and with ophthalmology examinations and evaluation services. UniCare generally will recognize modifier 25, for payment purposes, when modifier 25 is appropriately reported from both a clinical and coding perspective.
Modifier 26 Clinical Pathology Codes: Certain procedure codes when used in conjunction with a modifier describe either one or a combination of a physician component and a technical component of a service. When reporting the physician component of a code only, Modifier 26 should be used. When reporting with clinical pathology codes, no payment will be made except for select codes that require a separately identifiable professional interpretation beyond the technical component. The list of pathology codes for which Modifier 26 may be payable may change from time to time and is based in part of CMS guidelines.

Services billed without a modifier 26 are considered to be global services. Cardiac catheterization services should be billed with Modifier 26 to reflect the professional component.

Modifier 50 Bilateral Procedure: The maximum allowable rate for the surgical service may be increased by up to 50% for the bilateral procedure unless the service is otherwise identified as a single code.

Modifier 51 Multiple Procedures: Multiple Surgical Reduction rule (100%, 50%, 50% of maximum allowable rate) is normally applied to claims for multiple procedures performed at the same operative session. See Multiple Surgeries section following.

Modifier 52 Reduced Service: A 50% reduction will be applied to any reimbursement for services associated with this code. If these services are provided in conjunction with other surgical procedures, the standard approach to reimbursement for multiple surgeries will also apply.

Modifier 53 Discontinued Procedure: A 50% reduction will be applied to any reimbursement for procedures associated with this code. If these procedures are provided in conjunction with other surgical procedures, the standard approach to reimbursement for multiple surgeries will also apply.

Modifier 54 Surgical Care Only: Claim determination is normally based upon 70% of maximum allowable rate of the surgical procedure.

Modifier 55 Postoperative Management: When billed with a surgical CPT code claim determination is normally based upon 20% of the maximum allowable rate of the surgical procedure. If billed with an office visit code, there is no value change.

Modifier 56 Preoperative Management: When billed with a surgical CPT code claim determination is normally based upon 10% of the maximum allowable rate of the surgical procedure.

Modifier 62 Co-surgeons: Claim determination is normally based upon 63% of maximum allowable rate and 50% is normally allowed to each surgeon.

Modifier 63 Procedure Performed on Infants less than 4 kg: Claim determination is normally based upon 120% of maximum allowable rate.

Modifiers 73, 74 Discontinued Outpatient Hospital/Ambulatory Surgery Center Procedure Prior to/After Administration of Anesthesia: No reimbursement, since code is inappropriate for professional provider billing.

Modifier 78 Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period: Claim determination is normally based upon 70% of maximum allowable rate.

Modifiers 80, 81, 82 Assistant Surgeon: Claim determination is normally based upon 16% of the maximum allowable rate of the surgical procedure.
Modifier 99 Multiple Modifiers: All claims billed with this modifier are subject to medical review.

Modifier AS Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist services for assistant at surgery: Claim determination is normally based upon 14% of the maximum allowable rate.

Duplicate Professional and Technical Components
This rule considers component procedures (professional or technical) a duplicate if the global procedure is billed by the same provider for the same member on the same date of service. This edit is based on CMS coding guidelines; procedures with a “PCTC Ind” indicator in the National Physician Fee Schedule Relative Value File are included in this list of procedures.

Technical Only or Complete Service for Hospital Inpatient or Outpatient
No reimbursement. Physicians who provide clinical lab, pathology, radiology or other diagnostic testing services to hospital inpatients or outpatients shall only be reimbursed for the professional component fee allowance (when the code has a separate professional component RVU assigned based on CMS guidelines). There will be no reimbursement to the physician for the technical component only, or the complete service. Such reimbursement has been included in the payment to the hospital.

Anesthesia Modifiers QK, QX Medical Direction Claim determination is normally based upon 50% of the allowable rate.

Anesthesia
Rendering a patient insensible to pain during surgical, obstetrical and certain other medically necessary procedures caused by the administration of a drug or by other medical interventions.

General anesthesia. A state of unconsciousness with the absence of pain and/or sensation, produced by anesthesia agents that affect the entire body. Drugs that produce this state are administered intravenously, rectally, intramuscularly or by inhalation.

Regional anesthesia. The absence of pain and/or sensation produced by introducing an agent that interrupts the sensory nerve conduction to a specific area (region) of the body.

- Field block: Introduction of a local or topical anesthetic to produce the absence of pain and/or sensation to an operative area of the body.
  - Local anesthesia may be used in more than one area of the body. Any agent used to produce the absence of pain and/or sensation other than to the entire body is a local anesthetic.
  - Topical anesthesia includes local agents applied to the surface in areas such as eyes and mucous membranes where injections are not recommended or possible. Eye drops, creams and sprays are common topical agents.
- Nerve block: Introduction of an anesthetic agent close to a nerve so that conduction is cut off. Spinal and caudal anesthesia are types of nerve blocks into the spinal column. These types of anesthesia are often desired for abdominal or obstetrical surgery and affect a large area of the body.
Policy
Charges for anesthesia administration may be eligible for contract benefits when
1. provided by a physician, typically an anesthesiologist (MD, DO) or a Certified Registered Nurse Anesthetist (CRNA); and
2. performed in conjunction with a covered surgical, medical, obstetric or radiology service.

Anesthesia Services Most Often Eligible for Payment
- Services of an anesthesiologist or CRNA billed by a hospital on UB-92 are considered ancillary services and reimbursed according to the terms of the hospital agreement.
- Anesthesia, given in conjunction with a covered surgical or obstetrical procedure, where the anesthesiologist or CRNA is in constant attendance with the patient administering anesthesia, monitoring and managing life functions, managing unconsciousness, and/or managing fluid therapy (regardless of where the surgery is performed). Such care includes pre-anesthetic evaluation, intra-anesthetic record keeping and post-anesthetic follow-up.
- Anesthesia services for continuous epidural on obstetrical procedures requires the following information:
  1. Type of anesthesia (epidural, lumbar or caudal, or spinal)
  2. Start and stop time of labor anesthesia
  3. Start and stop time of delivery anesthesia
  4. Type of delivery performed
- Anesthesia, given in conjunction with certain covered non-surgical procedures, when the procedure requires that the patient be kept absolutely still or is too painful to be performed without anesthesia as identified with either a modifier code or a procedure code.
- Anesthesia services identified as qualifying circumstances (by the use of additional CPT codes 99100, 99116, 99135 and 99140).
- Anesthesia with Medical Direction (QK, QY, QK) will allow for allocation of payment between supervising Anesthesiologists and CRNA(s).
- Anesthesia physical status modifiers P1 and P2. (Modifiers P3 – P6 are normally eligible for payment in accordance with ASA guidelines.)
Anesthesia Services Often Not Eligible for Payment

- Anesthesia given in conjunction with a non-covered surgery or non-covered medical procedure.
- Field block local anesthesia administered by the surgeon who performed the surgery. Field block local anesthesia is included in the surgery value; however, the cost of the materials for the local (e.g., anesthetic agent) is eligible for benefits.
- The usual preoperative and postoperative visits, anesthesia care during the procedure, administration of fluids and/or blood and the usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry).

**Exception:** The following unusual forms of monitoring are not included in the price of anesthesia and may be payable in addition to the anesthesia services:

- intra-arterial, CPT 36620
- Swan-Ganz, CPT 93503

- Anesthesia services billed by the same provider (surgeon, radiologist or endoscopist) performing the procedure requiring the anesthesia.

Special Circumstances

- **Pain management.** Intravenous administration of drugs, where a machine controls the dosage and duration.
  - Patient Controlled Analgesia (PCA). UniCare often allows the initial consultation or set-up. If subsequent visits are billed, claims are subject to medical review for determination of medical necessity in accordance with the criteria in the Benefit Agreement.
  - Continuous Epidural (non Obstetric). This is extremely rare and usually billed for hospice care end term and is subject to Medical Review for benefit determination.

- **Nerve Block**
  - Administered by a surgeon, and performed by injection for the purpose of anesthesia or therapeutic pain control.
  - A nerve block procedure billed either with an anesthesia CPT or the nerve block procedure code with Modifier 30 or Modifier AA through AG performed in conjunction with a surgical procedure is considered anesthesia services. UniCare normally reimburses anesthesia using the base anesthesia unit value only. Time units are not allowed. Nerve block procedures not billed as anesthesia services are considered therapeutic and reimbursed as surgery.

**Exception:** Obstetrical claims billed with a nerve block CPT procedure code may be reimbursed as anesthesia.

- **Standby during Percutaneous Transluminal Coronary Angioplasty (PTCA)**
- **Hypnosis.** When used as anesthesia during surgery is subject to medical review.
- **Acupuncture.** Billed as an anesthesia service.
- **Unusual anesthesia.** Billed with Modifier 23. Indicates unusual circumstances. Documentation must be provided to support the unusual circumstances and will be subject to medical review for benefit determination.
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Special Notes
- When two or more anesthesia procedures are billed during the same operative session, the anesthesia allowable amount will be determined by the procedure with the greater anesthesia units plus time units.
- If a second procedure begins more than one hour after the anesthesia end time of the first procedure, both procedures are considered separate operative sessions and the base and time units of each procedure normally are considered separately.

Obstetrical Anesthesia
The time for continuous lumbar epidural, caudal or spinal injection anesthesia when used during labor and delivery (01967) is calculated at one unit for every hour or fraction (e.g., 01-60 minutes equals one unit; 61-120 minutes equals two units, 121-180 minutes equals three units, etc.). There is no differentiation between continuous epidurals for vaginal and cesarean deliveries. If a scheduled vaginal delivery subsequently results in a cesarean delivery, codes 01967 and 01968 must be billed.

Anesthesia Allowance
The allowable amount for anesthesia services is normally determined by multiplying the sum of the base units for the service and the time units expended by the appropriate conversion factor. Anesthesia time units are normally calculated in units of 15 minutes (in increments of 5 minutes unless noted otherwise).

Anesthesia Time
Anesthesia time units are calculated in units of 15 minutes unless noted otherwise. Total number of minutes must be included on all anesthesia claims in field 24G of the CMS 1500.

Anesthesia Codes and Modifiers
UniCare requires current CPT codes 00100 – 01999 for anesthesia administration claims. (CPT codes 00100 – 01999 identify the section of the body where the procedure was performed, not the type of procedure performed.) UniCare does not allow the practice of billing anesthesia services using surgical codes with a modifier. In addition, when two or more surgical procedures are performed during the same operative session, only the anesthesia procedure with the higher base unit value is allowed for reimbursement.

Multiple Surgeries
Multiple surgery claims are normally priced based on major and minor procedures performed on the same date of service during the same surgical session. The surgical procedure with the highest UniCare unit value is considered the major procedure and is priced at 100 percent of the unit value. The minor surgeries have a lesser unit value and are normally reduced as follows:

- **Incidental Surgery.** A surgical procedure that is performed as part of another surgery and should not be billed separately (commonly referred to as ‘unbundling’). The charge for the incidental procedure is included in the provider’s write-off.
- **‘As Is’ Surgeries.** Surgeries outside the Integumentary System (CPT range 10040-19499) that are always subsequent procedures (e.g., additional segment, suture of additional nerve). These surgeries are always billed with another surgery and never billed as stand-alone procedures.
- **Bilateral Surgery.** Surgeries performed through separate incisions to matching parts of the body (e.g., both shoulders). These surgeries are identified either with the surgical procedure and modifier 50, or the surgical procedure billed twice with modifier 50 attached to the second procedure.
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- **Block Procedures.** Surgeries in the Integumentary System that consist of a parent code and subsequent procedures, which merely increase the complexity of the parent procedure. The entire ‘block’ is considered one surgery.

**Additional Information**
1. Major and minor surgeries are priced line-by-line based on the UniCare allowed amount and not by the billed charges of the procedure on the claim.
2. Surgeries in the medical range (91000-99195) are normally **not** subject to the multiple surgery reductions.
3. The Medical Review Unit (MRU) will normally evaluate claims with more than five surgical procedures during the same operative session; *or*
4. one or more unlisted procedures
5. (Detailed operative reports may be required.)
6. Modifier 51 is used when multiple surgical procedures are performed and applies to the services of the surgeon only.

**Multiple Surgery and Endoscopy Procedures**
Unless state law requires otherwise, multiple endoscopy surgical procedures performed in the same operative session and are within the same base code family will be subject to multiple procedure reduction. The reduction percentage will vary by code family. The code ranges and percentages are as follows:

<table>
<thead>
<tr>
<th>Base Family</th>
<th>Codes</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder arthroscopy</td>
<td>29805 – 29826, 29827 – 29828</td>
<td>100% primary; 30% subsequent</td>
</tr>
<tr>
<td>Elbow arthroscopy</td>
<td>29830 – 29838</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Wrist arthroscopy</td>
<td>29840 – 29847</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Hip arthroscopy</td>
<td>29860 – 29863</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Knee arthroscopy</td>
<td>29870 – 29887</td>
<td>100% primary; 35% subsequent</td>
</tr>
<tr>
<td>Bronchoscopy</td>
<td>31622 – 31631, 31635 - 31636, 31638, 31640 – 31641, 31645</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Upper GI endoscopy</td>
<td>43231, 43232, 43235 – 43259</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>45378 – 45392</td>
<td>100% primary; 25% subsequent</td>
</tr>
<tr>
<td>Retrograde Cholangiopancreatography (ECRP)</td>
<td>43260 – 43265, 43267 – 43269, 43271 – 43272</td>
<td>100% primary; 25% subsequent</td>
</tr>
</tbody>
</table>

Other endoscopy code families and surgery procedures, not specified above, will be reimbursed based on multiple surgery reduction (MSR) policy of 100% for the primary and 50% for each payable subsequent procedure.

The primary surgery designation for all MSR will be based on the highest relative value based on CMS National Physician Fee Schedule Relative Value File.
Global Surgery Policy

- **Services/Supplies for Same Day Procedures.** Identifies service/supply codes that are not separately reimbursed when billed on the same day as surgery or procedure. These bundled services may include, but are not limited to:
  - Demonstration and/or evaluation of the use of an inhaler/nebulizer when performed with an evaluation and management service.
  - Interpretation and report of a routine EKG when performed with an E/M service.
  - Preventive medicine counseling when performed with a routine comprehensive preventive medical examination.

- **Unrelated E/M Services During the Post-op Period.** Services by the same physician, or a member of the physician’s group practice with the same tax ID number during the post-operative period, should be reported by appending modifier 24 to the E/M code. In addition to reporting modifier 24, the diagnosis code should be different than the diagnosis for the surgical service. A different diagnosis is defined when the first three digits of the diagnosis code differs from the first three digits of the diagnosis code reported for the surgical procedure.

- **Same Day Medical Visit.** ClaimsXten® identifies when an E/M visit is billed on the same day as a surgical procedure, substantial diagnostic or therapeutic procedure such as dialysis, chemotherapy and osteopathic manipulative treatment. An E/M code reported by the same provider on the same DOS is included within the global reimbursement for the procedure.

- **Pre-Op/Post-Op Rule. Pre and Post Operative Visit Editing.** Pre- and post-op evaluation and management (E/M) services by the same physician, or a member of the physician’s group practice with the same tax ID number, will be considered part of the surgical procedure reimbursement and will not be paid separately. When these services are rendered during the global surgical period as defined by CMS, ClaimsXten® will look across current and history claims to deny the E/M code if billed during the global surgical period.

CMS does not include all CPT codes in one of these three categories. Procedures that are not placed in these major categories are listed in supplemental categories of ‘MMM’, ‘XXX’, ‘YYY’, and ‘ZZZ’.
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Where CMS does not define global period, the following tables show examples of applicable postoperative days assigned by UniCare.

### MMM
“0” postoperative days except the following:
- “45” days for codes: 59400, 59410, 59510, 59610, 59614, 59618, and 59622.
- “10” days for codes: 59409, 59514, 59612, 59620 (These are “delivery” only codes.)

### XXX
“0” postoperative days

### YYY
UniCare reserves the right to apply a global period for aftercare based on the postoperative days designated for a similar procedure. Please see new table below for YYY designations.

### ZZZ
Same postoperative days as the parent procedure. For example: CPT 22585 will be assigned the same 90-day period as parent code 22554

#### YYY Designation Table:

<table>
<thead>
<tr>
<th>Applicable Postoperative Days</th>
<th>CPT Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>17999, 38589, 40899, 41899, 68899</td>
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<tr>
<td>45</td>
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</tr>
<tr>
<td></td>
<td>69949, 69979</td>
</tr>
</tbody>
</table>

#### Bilateral Billing
A bilateral procedure should be reported as a single line with the procedure code, one unit of service and modifier 50. If a bilateral procedure is submitted as two lines and one does not contain modifier 50, both line items will be denied and a new line item will be created with the code and modifier 50, and charges from both lines will be combined.
Section 4 Billing/Claims Coding and Submission: UniCare PPO Texas

**Bundled Services/Supplies.** Identifies services and supplies that are considered part of overall care and are not separately reimbursed. Modifier 59 will not override this edit.

Following are inclusive procedure(s) and supply code(s) that are not reimbursed even if reported alone:

1. Administrative services requiring physician documentation (e.g. recertification, release forms, physical/camp/school/daycare forms, etc.)
2. All practice overhead costs, such as heat, light, safe access, regulatory compliance including CDC and OSHA compliance, general supplies (paper, gauze, band aids, etc.), insurance (including malpractice insurance), collections
3. Collection/analysis of digitally/computer stored data
4. Computer aided detection with chest radiography
5. Copies of test results for patient
6. Costs to perform participating provider agreement requirements, such as prior authorizations, appeals, notices of non-coverage
7. Determination of venous pressure
8. DME delivery and/or set up fees
9. Handling and/or conveyance fees
10. Heparin lock flush solution or kit for non therapeutic use
11. Insertion of a pain pump by the operating physician during a surgical procedure
12. Peak expiratory flow rate
13. Photography
14. Pharmacy dispensing services and/or supply fees, etc.
15. Physician care plan oversight
16. Post op follow up visit during the global period for reasons related to the original surgery
17. Prescriptions, electronic, fax or hard copy, new and renewal, including early renewal
18. Pulse oximetry
19. Recording or generation of automated data
20. Review of medical records
21. Robotic surgical system
22. Routine post surgical services such as dressing changes and suture removal
23. Supplemental tracking codes for performance measurement (Category II CPT Codes)
24. Surgical/procedural supplies and materials supplied by the provider rendering the primary service (e.g. surgical trays, syringes/needles, sterile water etc.)
25. Telephone consultations with the patient, family members, or other health care professionals
26. Team conferences to coordinate patient care
27. Handling or conveyance of laboratory specimens
Section 4 Billing/Claims Coding and Submission: UniCare PPO Texas

The list below includes, but is not limited to, services that are not eligible for separate reimbursement when reported with another specific procedure or service.

1. Demonstration and/or evaluation of the use of an inhaler/nebulizer when performed with an evaluation and management service.
2. Interpretation and report of a routine EKG when performed with an evaluation and management service.
3. Preventive medicine counseling when performed with a routine comprehensive preventive medical examination.

Obstetrical Services

- **Global Delivery.** When a physician reports a routine maternity E/M or antepartum care service within 270 days of a global maternity delivery. If detected, the additional E/M and antepartum care services may be denied based on CPT coding guidelines governing what is included in the total obstetric package.
  - The global period does not include the initial office visit for diagnosis of pregnancy but includes all subsequent E/M visits reported with a normal pregnancy diagnosis. Global services are reimbursed according to a global fee.
  - Additional office visits for any unrelated condition or diagnosis code not within the range for normal pregnancy diagnosis are eligible for separate reimbursement.
  - A 45-day postpartum period applies for maternity delivery codes.

- **Multiple Vaginal Deliveries.** Should be billed with a global delivery code for the first delivery and a vaginal “delivery only” code for each additional birth. Additional deliveries are subject to the standard multiple surgical reimbursement policy:
  - Global delivery code: 100% of the maximum allowance.
  - Vaginal “delivery only” code, with modifier 59 appended: 50% of the maximum allowance.

- **Multiple C-Section Deliveries.** Only the global C-Section code will be reimbursed; no additional reimbursement is allowed for additional births when all babies are delivered by C-Section. Modifier 22 may be appended to the global or “delivery only” C-Section code if the physician work required for the multiple births is substantially greater than typically required. Documentation supporting the additional work must be submitted with the claim. “Additional work” includes, but is not limited to, increased intensity, time, technical difficulty of procedure and severity of patient’s condition.

- **Combined C-Section and Vaginal Multiple Deliveries**
  - Global vaginal delivery code for first delivery
  - C-Section “delivery only” code with modifier 59 appended for additional C-Section deliveries. Additional deliveries are subject to the standard multiple surgical reimbursement policy.
Laboratory Multi-code Rebundling. When codes that are part of a comprehensive multiple component blood test, described in the Laboratory section of CPT, are reported separately:

- Either the individual codes will be denied and the code representing the comprehensive procedure will be added to the claim for reimbursement; or
- The total eligible reimbursement for the separately reported codes will not exceed the maximum allowance for the single comprehensive code.

PAP Smear with E/M Code
Pap smear lab codes are not eligible for separate reimbursement when billed with E/M codes. In most cases when a family physician, internist or obstetrician/gynecologist submits a cytopathology/pap smear code, these are the physicians who obtained the specimen, not the pathologists preparing and/or interpreting the pap smear. The pathologist preparing and interpreting the cytopathology/pap smear must bill for this service separately.

The list below includes examples of pap smear codes that are to be reported by the pathologists, not by the physician who is obtaining the specimen.

- 88141 – 88155
- 88164 – 88167
- 88174 – 88175

Explanation of Benefits (EOB)
An Explanation of Benefits statement (EOB) is generated when a claim is finalized. This includes detail line information, a summary of the payment and the member’s responsibility. The only charges for which the member may be billed are

- copayment amounts required by the member’s benefit agreement and
- medical services excluded by the member’s benefit agreement if the member has agreed in advance to pay these charges.
Common Reasons for Rejected and Returned Claims

UniCare must sometimes return a claim for further information. Many of these returned claims result from incomplete or incorrect billing. Following are some of the more common reasons for returning a claim:

**Date of injury not provided.** When charges represent an injury diagnosis, always provide a date of injury.

**Duplicate billings.** Overlapping dates of service for the same service(s) will create a questionable duplicate bill.

**ICD-9-CM codes denied.** Claims that are coded with a preliminary, rather than a definitive diagnosis, will be mailed back for the definitive diagnosis.

**Medical records needed.** UniCare may require medical records before processing a claim. If medical records are required but are not submitted with the original claim, then a request form will be sent. **When sending the requested records to UniCare, attach the records to the original request form.** Do not reattach a new copy of the claim.

**NOTE:** Do not combine other request forms in the same envelope.

**Unlisted HCPCS codes submitted without description.** When submitting claims electronically, enter the description in the REMARKS field.

**Unreasonable numbers submitted.** Unreasonable numbers such as “9999” in the UNITS field.

Claims Appeals

A claim appeal is a formal written request from a provider for reconsideration of a claim already processed by UniCare. A written appeal for reconsideration of a denied claim or a claim the provider believes has been paid incorrectly should be submitted within 180 days from the date on the Explanation of Benefits along with a copy of the claim and any supporting documentation. Use the Claims Appeal Form or a detailed cover letter and mail to

UniCare
Attention: Appeals
PO Box 4458
Chicago, Illinois  60680

UniCare will provide a response within 60 days of receipt of the appeal.
Section 5 Customer Service: UniCare PPO

UniCare Customer Service Representatives are available weekdays during business hours to assist members and providers.

Available Information
Customer Service representatives are responsible for providing information about the following:

- Claim status
- Eligibility
- Benefit inquiry
- Coverage limitations and/or exclusions
- Identification of participating physicians, other medical providers and facilities
- Confirmation of provider network participation status

The Customer Service automated system provides claim status check and fax-back eligibility confirmation. Provider tax identification and fax numbers are required.

The Customer Service telephone number can be found on the member’s identification card. If the ID card is not available, please call 1-877-UNICARE. A representative will identify the appropriate unit and route your call.

The Customer Service phone number appears on the member’s identification card.
Section 6 Credentialing and Recredentialing: UniCare PPO

Prior to acceptance into the UniCare network, providers and physicians must undergo a formal credentialing process. This section describes the credentialing and recredentialing processes, UniCare’s Credentialing Committee and the appeal process for providers whose network participation has been terminated.

UniCare requires providers to complete the credentialing and recredentialing process through the Council for Affordable Quality Healthcare (CAQH). This process eases the administrative burden by allowing applications for multiple organizations through the use of a single, secure electronic format. CAQH also permits updates to data.

CAQH
The Council for Affordable Quality Healthcare (CAQH) is a not-for-profit alliance of health plans and networks. It advocates collaborative initiatives to promote health care affordability, information sharing to improve the quality of care and ease of administration for physicians and their patients.

Universal Credentialing DataSource was developed by health plans collaborating through CAQH to expedite the credentialing application process by eliminating the need to complete multiple credentialing forms. This free service allows providers to provide information one time, online or by fax, to satisfy credentialing and recredentialing requirements of all participating health plans and organizations. Providers can update information anytime and changes are made available to the plans and organizations they authorize.

How to Submit Information
1. Contact the CAQH Help Desk at 888-599-1771 or email help@caqh.geoaccess.com to obtain a CAQH provider ID.
2. Log on to www.caqh.org to enter credentialing data at your convenience.

Credentialing Status
Call 1-800-848-7347

Confidentiality
• Information obtained during the credentialing or recredentialing process is confidential.
• Discussions of the Credentialing Committee are protected by federal peer review laws.
• All Credentialing Committee meeting minutes and provider files are stored in a secure manner accessible only to authorized personnel and are not reproduced or distributed except for credentialing/crecredentialing purposes or peer review.

Credentialing Process
UniCare has identified and developed minimum acceptable criteria for the following types of medical professionals:
• Medical Doctors (M.D.)
• Doctors of Osteopathy (D.O.)
• Podiatrists (D.P.M.)
• Chiropractors (D.O.)
• Behavioral health practitioners (Ph.D., L.C.S.W.)
Section 6 Credentialing and Recredentialing: UniCare PPO

The credentialing process involves
1. Collection of application and verification of credentials and documentation, including
   • Work history
   • State medical license
   • Education
   • History of state and/or federal sanctions
   • Information contained in the National Practitioner Data Bank
   • History of professional liability claims
   • Assessment of board certification for applicable providers
2. Review of completed credentialing files by the Credentials Committee. This committee is
   comprised of participating network physicians and meets at least quarterly.
3. Formal notification to provider of the credentialing decision.
   Note: UniCare complies with Texas H.B. 1594 Expedited Credentialing requirements.

Recredentialing Process
A provider’s continuing participation in the UniCare network depends upon successful completion of
the recredentialing process. This process includes
   • Verification of continued state licensure
   • Verification of current board certification
   • Review of history of state and/or federal sanctions
   • Query to the National Practitioner Data Bank
   • Review of professional liability claims history

Termination of Network Participation Status
A provider’s status may be terminated at any time when information is obtained that indicates he/she
does not continue to meet UniCare standards. Issues that are brought to UniCare’s attention about
professional performance, licensure status and federal sanctions will be investigated by UniCare in a
fair and impartial manner. The UniCare Credential Committee will decide continued participation.

Appeal Process
Any provider whose network participation is terminated is advised in writing of his/her right to
request an appeal of the decision. The request and all relevant information are reviewed by a
committee of practicing providers. The provider making the appeal is notified in writing of the
outcome.
Section 7 Pharmacy: UniCare PPO

Many UniCare benefit plans include a pharmacy component overseen by WellPoint Pharmacy Management (WPM). Pharmacy Customer Service representatives at the number listed on the ID card can provide names and locations of participating pharmacies.

Formulary

WPM has compiled a formulary to help manage prescription drug costs and benefit plan premiums for many of UniCare’s benefit plans. Drug inclusion decisions are made by the UniCare National Pharmacy and Therapeutics Committee comprised of physicians, pharmacists and other health professionals. The formulary is a reference guide and is not intended as a substitute for the physician’s clinical knowledge and judgment. The final decision regarding treatment or services remains with the physician and the member, regardless of whether the treatment or service is a covered service.

The drug formulary list is regularly updated and subject to change at any time. For a current list of authorized drugs, instructions concerning non-formulary drug prescribing and a statement of generic drug policy, consult the pharmacy website: www.wellpointrx.com and follow the prompts. Please note that some plans’ approved drug lists may differ from this national formulary.

NOTE: In Texas, formulary changes for prescription drugs covered for a member will not be applied until the member’s renewal date.

Drugs that are not part of the UniCare list of preferred drugs are available from a pharmacy when the prescribing physician writes “do not substitute” or “dispense as written” on the prescription. Some drugs may require written prior benefit authorization. If you have a question regarding whether a particular drug is included in the UniCare formulary or requires prior benefit authorization, consult the UniCare website (www.unicare.com)

Utilization Review

Prescription drug benefits include utilization review of prescription drug usage for the member’s health and safety. If there are patterns of overutilization or misuse, UniCare will notify the physician and pharmacist. UniCare reserves the right to limit benefits to prevent overutilization.

If UniCare denies a request for prior benefit authorization of a drug that is not part of the UniCare formulary, the member or prescribing physician may appeal the decision.

Exception Processing – Pharmacy Prior Authorization

The WellPoint Pharmacy Management (WPM) Prior Authorization Center is responsible for processing initial prior benefit authorization requests. The WPM Prior Authorization Center is run by a pharmacist, and staffed by pharmacy technicians. They assess the information being faxed from the prescribing physician, review the completed form and determine the outcome. WellPoint Pharmacy Management can “approve,” define as “unnecessary,” or “defer” prior benefit authorization requests. In Texas, determinations of benefit preauthorization requests must be issued within three days (or less if the circumstances require shorter turnaround). If WPM is unable to “approve” the request, they will fax the form back to the physician requesting additional information.
Section 7 Pharmacy: UniCare PPO

Submit all pharmacy exception requests using a Pharmacy Prior Authorization Form. Members are notified within two days of the decision and prescribing physicians are notified within 24 hours. The Prior Authorization Form can be downloaded from the UniCare website or by calling the pharmacy phone number on the member’s ID card.

Network Pharmacies
UniCare members who are eligible for outpatient prescription drug benefits may have their prescriptions filled at any independently contracted network pharmacy. A full listing of local network pharmacies appears on the web site, www.unicare.com Members may contact Customer Service for assistance in locating a pharmacy.

Mail Order Pharmacy
Some UniCare health benefit plans include mail order pharmacy benefits administered through Precision Rx, WellPoint Pharmacy Management’s mail service pharmacy, which delivers maintenance medications to members. Maintenance medications are drugs taken on a regular or long-term basis. Formulary requirements will apply. When writing new prescriptions for members with mail order pharmacy benefits, please give the patient two written prescriptions for each drug. One will be used for immediate fill at a local pharmacy and the second is used for subsequent refills through Precision Rx.
Section 8 HIPAA: UniCare PPO

The Health Insurance Portability and Accountability Act (HIPAA) was passed to reduce healthcare administrative costs, protect individuals’ privacy and insurability, and enhance measures to limit fraud and abuse. The Act contains several components mandating continuing health benefit coverage in certain situations, privacy, electronic data submission and code sets and medical record security.

UniCare’s goal is to ensure our systems, supporting business processes, policies and procedures successfully meet the mandated implementation standards and deadlines. We strive to be in full compliance with all applicable current requirements and expect to be compliant with future requirements as they are due.

The UniCare website at www.unicare.com provides extensive information about rules governing coding, data transmission and patient privacy.
Section 9 Glossary of Terms: UniCare PPO

Glossary of Terms

**Benefit Agreement(s).** A group or individual insurance policy or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness, where Members have a financial incentive to use designated participating physicians, hospitals or other health care professionals, and any other UniCare policies or contracts that may be offered from time to time.

Benefit Agreement also means other arrangements established by UniCare, or by other persons or entities (other payors) using the UniCare health care professional network pursuant to a contractual arrangement with UniCare.

**Case Management.** Arranging, negotiating and coordinating benefits for medically appropriate care in an effective and coordinated manner during prolonged periods of intensive medical care, including using benefit substitution, based on the Member’s Benefit Agreement.

**Coordination of Benefits.** The method of determining primary responsibility for payment of covered services under the terms of the applicable Benefit Agreement, and applicable laws and regulations, when more than one payor may have liability for payment for services rendered to a Member.

**Covered Services.** Medically necessary health care services that are covered by a Benefit Agreement.

**Emergency**

**Illinois**

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

1. permanently placing the member’s health in serious jeopardy;
2. causing other serious medical consequences;
3. causing serious impairment of bodily functions;
4. causing serious and permanent dysfunction of any body organ or part.

**Texas**

A recent onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including, without limitation, sudden and unexpected severe pain) that would lead a prudent lay person possessing an average knowledge of medicine and health to believe that the person’s condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

1. placing the member’s health in serious jeopardy;
2. causing serious impairment of bodily organs;
3. causing serious dysfunction of any bodily organ or part;
4. serious disfigurement;
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

In the case that this meaning conflicts with applicable law or regulations such law or regulation shall control.

**Medical Director.** A duly licensed physician or designee who has been designated by UniCare to monitor covered services to members.

**Medical Management.** Functions, including case management, performed by UniCare as a utilization review agent to review and determine whether covered services provided, or to be provided, meet the criteria of medically necessary as set forth in the Benefit Agreement.
Section 9 Glossary of Terms: UniCare PPO

**Medically Necessary (Medical Necessity).** Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
3. not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

**Member.** An individual who is covered under a Benefit Agreement.

**Participating Physicians, Hospitals, Other Health Care Professionals and Facilities.** An independently contracted physician, hospital, other institutional facility, ancillary healthcare clinician, medical group or independent practice association or similar entity that has entered into an agreement with UniCare to provide Covered Services for prospectively determined rates.

**Provider Agreement.** An agreement entered into between UniCare or any of its affiliates and a provider in which both parties have agreed to terms relating to the provision of Covered Services to Members and the compensation to the provider for the provision of such Covered Services.

**UniCare Professional Network.** The network of Participating Physicians and other Health Care Professionals.

**Working Day.** Any day, Monday through Friday, excluding legal holidays.