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UniCare Health Plans of the Midwest
HMO Provider Operations Manual

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UniCare is a family of companies that designs and administers health benefit plans to members throughout the United States. The UniCare companies, which 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, Inc., one of the country’s largest publicly traded health care benefit companies.

UniCare is committed to working with physicians, other health care professionals and members to improve the health status of its members and to provide a high level of satisfaction in delivering quality care.

The UniCare Health Plans of the Midwest Provider Operations Manual is an integral part of this commitment. This manual is a summary of some of UniCare’s policies and procedures. UniCare reserves the right to modify, amend or implement policies and procedures, or establish new ones, 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: provider contracting and provider services. Our staff supports the provider network through the contracting, credentialing and recredentialing processes and provides ongoing education to providers and their office staffs.

How To Reach Us
On Call Desk Telephone 800-700-0668

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 number below.

Fax 312-234-8222

UniCare Provider Website

www.unicare.com

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

The website also features articles and other helpful resource materials for providers.
Glossary of Terms
There are many terms used throughout the manual that describe the various products, independently contracted physicians, hospitals, other health care professionals, organizations, and specialized services that relate to managed care. To help you identify the meaning of this specialized terminology, the following is a glossary of current terms.

Affiliate(s). A corporation or other organization owned or controlled, either in whole or in part, either directly or through parent or subsidiary corporations, by UniCare, or that owns or controls UniCare or is under common control with UniCare.

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.

Capitation Payment. The predetermined monthly payment payable to an IPA organization for provision of specified medical services.

Case Management. Arranging, negotiating and coordinating 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.

Copayment. Charges including, but not limited to, copayments, coinsurance and deductibles, which a member is required to pay for Covered Services under a 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
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

IPA Health Care Professional. An independent health care professional who is under contract, or on whose behalf a contract has been entered into, with the IPA.
Section 1 Introduction: UniCare Health Plans of the Midwest

IPA Participation Agreement. An agreement between an IPA and IPA physicians, hospitals and other health care professionals to provide Covered Services for members.

IPA Physician. An independent physician who is under contract, or on whose behalf a contract has been entered into with the IPA.

IPA Services Agreement. An agreement for specified Covered Services that the IPA arranges and for which the IPA is paid capitation.

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.

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.

Medical Practice. Physician(s) or entity that is required through an agreement with UniCare to provide Covered Services to members who have been properly referred to the medical practice, as applicable. If the medical practice is a corporation, association, or partnership, or if the medical practice employs, is associated with, or contracts with other physicians, hospitals and other health care professionals, all of the terms of the agreement will apply to such physicians, hospitals and other health care professionals associated, employed, and/or contracting with the medical practice and it will be the medical practice's obligation to ensure such compliance.

The medical practice agrees, and will require such physicians, hospitals and other health care professionals to agree that in the event of any inconsistency between the agreement and any contract between the medical practice and such physicians, hospitals and other health care professionals, the terms of the UniCare agreement will control.

Member(s). An individual who is covered under a Benefit Agreement.
Section 1 Introduction: UniCare Health Plans of the Midwest

Participating Physicians, Hospitals, Other Health Care Professionals and Facilities. An independently contracted hospital, other institutional facility, ancillary healthcare clinician, physician, licensed practitioner, 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 Health Care Professional Network. The network of independently contracted participating physicians and other health care professionals.

Utilization Review. Functions, including case management, performed by UniCare as a utilization review agent to review and determine whether services provided, or to be provided, meet the criteria for Medical Necessity as set forth in the Member’s Benefit Agreement.

Working Day. Any day, Monday through Friday, excluding legal holidays.
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
UniCare HMO compensates providers only for care rendered to eligible members. Member ID cards do not carry an expiration date, but the date of issue of an ID card may be found on the reverse side right hand corner. UniCare HMO members generally receive new ID cards at least once annually and upon any change of benefit plan or Primary Care Physician. 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 is an online tool that allows UniCare network 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. This verification is not a guarantee of 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 1-877-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 eligibility data for all UniCare members and is available at all times. The IVR is accessible via the telephone number on the member’s ID card. Be sure to have the member’s nine-digit member number and the provider’s tax identification number ready.

To receive a written confirmation of benefits, follow the prompts for the fax-back option.
Section 2 Eligibility: UniCare Health Plans of the Midwest

Reciprocity
UniCare members enrolled in other UniCare benefit agreements outside the Midwest service area and not currently accessing the UniCare Midwest network may access and utilize UniCare Midwest providers. In addition, dependents of employees enrolled in plans outside the UniCare service area may access and utilize UniCare Midwest providers if such dependents live in the Midwest 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 or her ID card when seeking medical services.

ID cards provide the following information:
1. Name
2. Certificate number
3. Employer group number or individual number
4. UniCare plan code
5. Coverage code
6. Primary Care Physician’s name and telephone number
7. Primary Care Physician’s IPA affiliation
8. Claims mailing address(es) and customer service telephone number(s) for the medical program and any supplemental benefits
9. Instructions regarding carrying and using the ID card
10. Guidelines for obtaining services and reporting emergencies
11. Telephone number for preauthorization
Section 3 Medical Management: UniCare Health Plans of the Midwest

UniCare’s Medical Management Department works with 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. Occasionally a benefit agreement excludes 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 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.
Preauthorization
UniCare encourages physicians’ office staff to initiate preauthorization on behalf of members, since clinical information is required. Please telephone the Customer Service number on the member’s ID card as soon as possible, but not less than three working days prior to a scheduled inpatient hospitalization or outpatient service.

Questions concerning preauthorization of treatment can also be directed to Customer Service at the telephone number on the member’s ID card.

Inpatient Services that require preauthorization
- Medical and surgical services including normal vaginal and c-section deliveries
- Out-of-area/out-of-network services
- Psychiatry/substance abuse services (800) 746-6294
- Skilled nursing facility, rehabilitation center, long term acute facility
- 23-Hour observation

Outpatient Services that require preauthorization
- Ambulatory surgery and procedures
- Diagnostic services (diagnostic radiology, genetic testing)
- DME rentals
- DME purchases exceeding $1000
- Home health care
- Hospice
- Infertility treatment
- Out-of-area/out-of-network services

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.

Required Information
The following information is required when authorizing care:
- 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 or surgery
- Hospital or facility name
- Name and telephone number of admitting physician

Concurrent Review
Concurrent review affirms continuing medical necessity and appropriateness of continued treatment, services or hospitalization. Review of ongoing care is required to obtain preauthorization of days beyond the goal length of stay as well as for outpatient procedures and ongoing outpatient care that require preauthorization.
Retrospective Review
Retrospective review is performed when services or treatment was performed but was not preauthorized by the Medical Management staff. A non-authorization notice will be issued if the retrospective review determines that services were not medically necessary.

Retrospective denials of preauthorized services will not be issued except in cases of a material misrepresentation of the proposed medical or health care services or a substantial failure to perform the preauthorized medical or health care services.

Case Management
Case Managers work with physicians to coordinate care 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-Authorization by Medical Management
Providers may request an appeal of a clinical benefit non-authorization by calling the Customer Service phone number on the member’s ID card or the number on the non-authorization 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 authorize benefits, a written notice will be issued. If the initial determination not to authorize 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-authorization.

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

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 unless the member has agreed in advance to pay these charges and UniCare has denied coverage.
Most independently contracted participating physicians belong to a medical group or IPA that receives monthly capitation payments for professional services to members assigned to PCPs of that medical group/IPA. The medical group/IPA is responsible for compensating primary care physicians and specialists for capitated services for assigned members. Medical groups/IPAs may use a combination of sub-capitation and fee schedule claim payments.

**Eligibility**
UniCare HMO compensates providers only for care rendered to eligible members. Member ID cards do not carry an expiration date, but the date of issue of an ID card may be found on the reverse side right hand corner. UniCare HMO members generally receive new ID cards at least once annually and upon any change of benefit plan or Primary Care Physician. Please call the Customer Service number on the member ID card to verify eligibility before each service. Verification of eligibility is not a guarantee of payment.

**Co-payments**
Each HMO member’s ID card identifies office visit co-payments. Some UniCare HMO members have different co-payment amounts for PCPs and specialists. Co-payments for Primary Care Physician visits are listed next to Office Visit and co-payments for Specialist visits are listed next to Spec. Prenatal visits, nurse visits and post-surgical visits during the global period normally are not subject to co-payment.

**Claims Submission**
Submit claims for capitated services directly to the IPA/medical group whenever possible.

Claims covered under capitation that are misdirected to UniCare will be redirected to the responsible IPA/medical group as follows:

1. Routinely, any claim received by UniCare for capitated services is recorded in the UniCare system as a "capitated liability" and redirected to the capitated entity for processing. A letter is sent to the billing physician, hospital or other health care professional indicating that the claim has been redirected to the capitated entity. The capitated entity’s name, address, and telephone number are printed on the letter. At the same time, a letter accompanied by a facsimile copy of the claim is sent to the IPA entity.

2. If a claim has been redirected on more than one occasion, or in the event of a member complaint, UniCare claims personnel contact the capitated entity to obtain status on its disposition. If status is not immediately available, the capitated entity is given two business days to respond regarding the claim disposition, with check date and number if the claim has already been paid. Contracted IPAs are required to send UniCare written confirmation of any claims the IPA believes should be denied. UniCare then issues the denial notice.

3. If, after an investigation, it appears that an IPA physician, hospital or other health care professional has failed to post his/her accounts with the proper contractual allowance, UniCare expects the IPA or medical group to take aggressive action to compel the physician or other health care professional to cease balance-billing activity. Such action should, at minimum, include a telephone call followed by written confirmation (a copy of which should be forwarded to UniCare).
4. In the absence of any response from the capitated entity regarding the claim’s disposition within the usual two business days, UniCare HMO will process the claim and reduce the subsequent month’s capitation check in the amount of any payment.

5. When a medical group/IPA denies or reduces payment to its own contracted physicians, hospitals and other health care professionals for internal administrative reasons (e.g., the IPA’s submission guidelines not followed, sub-capitated service, services bundling, etc.), UniCare HMO members may not be balance-billed. An IPA health care physician is in breach of his/her contract if s/he bills a member for an eligible service.

6. If a claim is denied by the capitated entity in circumstances where the member may be responsible for payment (e.g., member was "out of plan"), written notification stating the reason for the denial must be provided to UniCare. UniCare assumes responsibility for issuing a formal denial notice to the member describing his/her payment obligations and advises the member of his/her appeal rights. Denied claim notices must be sent to UniCare HMO via the attached Return IPA Claim Form request to deny.

7. If a denial is appealed and overturned, UniCare will issue payment (which may be deducted from capitation).

   Note: All denials are subject to review by the UniCare HMO Medical Director.

8. Additional claim status information may be sent with accompanying Return IPA Claim Form attached to each returned claim.

IPA Claim Payment Responsibility

UniCare may audit medical group/IPA claims payments from time to time. The Agreement with UniCare obligates the capitated entity to cooperate with such an audit, both for itself and for its member physicians. UniCare may review claims payment procedures and determine an IPA organization’s ability to comply with the requirements of the claims payment responsibility. Specialists and Primary Care Physicians who are members of medical groups/IPAs are expected to deal directly with the group/IPA regarding its payment policies and procedures. It is a breach of the Provider agreement to bill a member for eligible services provided pursuant to a PCP referral. Physicians who pursue members for payments covered by capitation are subject to termination from network participation.

HMO Benefits Riders

UniCare HMO defines limitations to certain kinds of benefits (e.g., annual number of outpatient rehabilitation therapy visits) in the member’s Benefit Agreement or in riders. The Benefit CD ROM file identifies each limitation and provides details of each member Benefit Agreement. The capitation system includes the member benefit plan number for reference to the data contained in the Benefit CD ROM file. Capitated entities need to refer to these codes when administering services covered by the capitation payment. Please call Customer Service at the number on the member’s ID card if you have any questions about member benefits.

Claims Paid by UniCare

UniCare HMO pays physicians, hospitals and other health care professionals directly for covered services provided to non-capitated members. UniCare may also be responsible for processing specialty physician claims for specified services such as infertility conditions, family planning, and transplant services.
Stop Loss
Certain UniCare HMO capitation contracts with medical groups/IPAs may provide for reinsurance by UniCare of a portion of claims paid by the group/IPA for services to members whose total claims exceed the dollar threshold ("stop loss") specified in the contract. Groups/IPAs must submit evidence of claim payment, including photocopies of original claims and copies of canceled checks. Stop Loss claims may be sent at any time during the calendar year the claim is incurred. The deadline for submissions is May 30 of the year following the incurred period; claims received after the submission deadline are not eligible for reimbursement. A stop loss submission form should accompany each submission.

Encounter Data
UniCare requires contracted IPAs with capitated contractual arrangements to submit encounter data through an electronic clearinghouse on a monthly basis. Encounter data must include all services provided under the capitation arrangement as well as claims paid by the IPA/medical group. HIPAA standard codes are required for all data submitted. UniCare electronic encounter data is processed by Diversified Data Design. Please contact your Network Services Specialist to review specifications for data submission.

Direct Deposit Capitation Payments
Capitation payments can be deposited directly to the IPA or medical group bank account by the 15th of each month upon completion of the following two forms.

Direct Deposit Authorization Form
The Direct Deposit Authorization form authorizes UniCare to initiate deposits and/or correction amounts to the IPA or medical group bank account. This form requires the following information:
1. A blank deposit slip attached to the form
2. Physician or other health care professional information and bank information as specified on the form
3. Authorization by an IPA or medical group authorized representative, and his/her information as specified on the form
4. Direct deposit forms for IPAs and medical groups are available.

Request for Electronic Funds Transfer Form
The Request for Electronic Funds Transfer form asks UniCare to wire capitation funds, and provides UniCare with an authorized representative or agent who will be responsible for setting up the electronic funds transfer (EFT). The form requires the IPA or medical group name; authorization by the IPAs or medical group’s authorized representative and the representative’s information as specified on the form.
In the event that the IPA or medical group sets up EFT capability with a billing service, EMC vendor, or other party, rather than directly with UniCare, a release letter is also required. The release letter needs to be written on the IPA’s or medical group’s letterhead, stating (1) the name and address of the IPA’s or medical group’s agent, (2) the scope of the agent’s authority, and (3) that the agent is both aware of and has agreed to be bound by all applicable state and federal laws and regulations with regard to patient confidentiality. The release letter must be signed by an authorized representative of the health care partner. Should the IPA or medical group change or terminate its agent, a new release letter must be given to UniCare. UniCare will not be responsible for any EFT transactions sent to a terminated agent if a new release letter has not been communicated to UniCare.

Call Network Services at 800-700-0668 to obtain electronic funds transfer forms.
Section 5 Fee for Service Billing/Claims Coding and Submission: 
UniCare Health Plans of the Midwest

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.
Section 5 Fee for Service Billing/Claims Coding and Submission:
UniCare Health Plans of the Midwest

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](http://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 5 Fee for Service Billing/Claims Coding and Submission:
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*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.

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](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.
Section 5 Fee for Service Billing/Claims Coding and Submission: UniCare Health Plans of the Midwest

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
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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 5 Fee for Service Billing/Claims Coding and Submission: UniCare Health Plans of the Midwest

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 (Cocoa)
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 5 Fee for Service Billing/Claims Coding and Submission:
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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.
Section 5 Fee for Service Billing/Claims Coding and Submission: UniCare Health Plans of the Midwest

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 5 Fee for Service Billing/Claims Coding and Submission: UniCare Health Plans of the Midwest

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.
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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 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.
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- For additional 30 minute increments, documented service and time frames need to be at least 15 minutes or more to be reported.

**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.
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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.
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.

- **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*
   - 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’.
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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>
<tr>
<td>XXX</td>
<td>“0” postoperative days</td>
</tr>
<tr>
<td>YYY</td>
<td>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.</td>
</tr>
<tr>
<td>ZZZ</td>
<td>Same postoperative days as the parent procedure. For example: CPT 22585 will be assigned the same 90-day period as parent code 22554</td>
</tr>
</tbody>
</table>

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>
<tr>
<td>90</td>
<td></td>
</tr>
</tbody>
</table>
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**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
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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.
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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.
UniCare compensates providers only for care rendered to eligible members. Member ID cards do not carry an expiration date, but the date of issue of an ID card may be found on the reverse side right hand corner. UniCare HMO members generally receive new ID cards at least once annually and upon any change of benefit plan or Primary Care Physician. Call the Customer Service number on the member ID card to verify eligibility before each service. Of course, services rendered to persons who are not eligible with UniCare HMO may be charged directly to the patient. Verification of eligibility is not a guarantee of payment.

**Office Visit Copayments**
If the member’s ID card indicates a copayment, refer to the sections below to determine when the copayment applies.

Office visit copayments may be collected at the time the following services are rendered:
- Primary care physician (PCP) office visits
- Specialty care physician office visits
- Physical, occupational, or speech therapist visits in an office or outpatient setting
- Podiatrist office visits (specialty care copayment applies)
- Chiropractic office visits (specialty care copayment applies)
- Mental health outpatient visits (a special outpatient mental health copayment may be indicated on the ID card)
- Nurse practitioner office visits

A copayment may **not** be collected for the following:
- Ongoing prenatal visits to an obstetrician, since the global obstetrical fee includes prenatal visits. (A copayment may be collected for the visit when the pregnancy diagnosis is established.)
- Pre-surgical and surgical follow-up visits covered by a global surgical fee.
- X-ray, allergy injection, blood test, EKG, or other office service performed in absence of physician and nurse practitioner office visit.
- Outpatient facility charges from a hospital, ambulatory surgery center, dialysis center, or specialized radiology center. Professional charges may be subject to copayment (e.g., physical therapy, outpatient mental health, physician clinic charges, etc.).
A few examples:

1. The member is treated by a physician and has laboratory tests run in the physician’s office: a single copayment is collected in conjunction with the physician visit.

2. The member is treated by an office nurse who administers an allergy injection: no copayment is collected.

3. The PCP treats the member and also refers the member to a specialty care physician: two copayments may be collected, one by the PCP and one by the specialist.

4. The member is referred to a surgeon for initial consultation, has surgery performed a month later that requires follow-up visits in the immediate post-op period. The surgeon may collect a copayment for the initial office consultation. Since the pre-surgical visit and post-op care are considered part of the global surgical fee, no copayment may be collected.

**Pharmacy**

UniCare has designed and implemented a state-of-the-art managed care pharmaceutical program with a goal to reduce and control unnecessary costs while increasing the quality of care. UniCare’s online Prescription Drug Program’s cost containment features include negotiated pricing, reduced administrative costs, collecting utilization data, eliminating coverage for ineligible subscribers and noncovered items, and increased generic substitution. 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.

**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 is contained in the HMO directory or on the web site. 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.

**Drug Formulary**

UniCare has a Drug Formulary Program that is designed to help manage rapidly escalating prescription drug costs while remaining flexible and sensitive to members’ medical needs. Formulary drugs that have equivalent medical results will be substituted for non-preferred medications on approval from the prescribing physician.

A list of outpatient prescription drugs was developed by the UniCare Pharmacy and Therapeutics Committee, which includes independent physicians and pharmacists. The committee reviews the current medical literature to ensure that safe, appropriate and medically necessary medications are included in the formulary. The committee updates this list quarterly, ensuring that cost-effective, therapeutic drug choices are included.
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. Consult the UniCare website
(www.unicare.com) for information regarding whether a particular drug is included in the
UniCare formulary or requires prior benefit authorization.

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.

Pharmacy 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.

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 whether benefits
are available. WellPoint Pharmacy Management can “approve,” define as “unnecessary,” or
“defer” prior benefit authorization requests. If WPM is unable to “approve” the request, they will
fax the form back to the physician requesting additional information.

All pharmacy benefit exception requests must be submitted via 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 (www.unicare.com) or by calling the pharmacy phone number on the member’s ID card.

Diagnostic Laboratory Services
UniCare has contracted with a number of independent national providers for a range of covered
benefits and services. Information including locations is available by calling the numbers below.

LabCorp (800) 877-5227
Quest Diagnostics (800) 824-6152
Path Labs (800) 258-1441
Clinical Pathology Laboratories (800) 633-4757

Physicians who are reimbursed under a capitation Agreement should check with their
IPA/medical group for preferred laboratories.

Laboratory services performed during the course of an inpatient confinement, observation stay,
emergency room visit or ambulatory surgery are considered part of the facility service.
Section 6 Benefits Administration: UniCare Health Plans of the Midwest

**Woman’s Principal Health Care Provider**
Female members may access designate independently contracted network OB/GYN specialists as their “Woman’s Principal Health Care Provider” and access their services without prior benefit authorization from UniCare or their PCP. The OB/GYN must have a referral relationship with the member’s PCP. A referral relationship exists when two or more doctors practice in the same medical group and share the same Provider ID number.

Physicians should notify UniCare of a diagnosis and care of pregnancy by calling the Customer Service number on the member’s ID card.

**Mental Health/Chemical Dependency Services**
UniCare allows members to refer directly to contracted UniCare behavioral health providers for mental health/chemical dependency treatment. Whether a patient is referred or has sought care independently, UniCare’s Behavioral Health unit will coordinate any necessary benefit authorizations prior to rendering services.

Behavioral Health medical necessity criteria and clinical practice guidelines are available online by linking to Behavioral Health at [www.unicare.com](http://www.unicare.com). Health care providers may also call the Behavioral Health unit at 800-746-6294 for benefit authorizations or other information.
Prior to acceptance into the UniCare network, providers must undergo a formal credentialing process. This section describes the credentialing and recredentialing processes, UniCare’s Credential 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 Credential Committee are protected by federal peer review laws.
- All Credentialing Committee meeting minutes and provider files are stored in a secure manner and are 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.)
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 Credential Committee. This committee is comprised of participating network physicians and meets at least quarterly.
3. Formal notification to provider of the credentialing decision.

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.
Physicians
UniCare HMO is committed to educating members and independently contracted physicians participating in the HMO about both rights and responsibilities. This section reviews many of the UniCare participating physician and medical professional’s rights and responsibilities. In addition, this section provides an overview of member rights and responsibilities.

UniCare requires each independently contracted participating physician to designate his/her medical/surgical specialty at the time of initial application. In general, Family Practice, General Internal Medicine and General Pediatrics are considered Primary Care Physicians (PCP). PCPs are responsible for the coordination and organization of health care for their enrolled members.

Medical/Surgical specialists who are not PCPs are considered by UniCare to be Specialty Care Physicians (SCP). Members do not enroll with SCRs. In general, a specialist will only see members by referral from the member’s PCP. However, female members may also designate a Woman’s Principal Health Care Provider without referral. Woman’s Principal Health Care Providers are defined as doctors recognized as specialists in OB/GYN or Family Practice.

The relationship between UniCare and independently contracted participating physicians is governed by the Participating Provider agreement entered into between the parties, which in turn requires compliance by the participating provider with this provider manual.

Participating PCP Responsibilities
1. Regular checkups
2. Referrals to network specialists, when appropriate
3. Arranging outpatient services
4. Arranging hospitalizations
5. Providing appropriate health education for members
6. Complying and cooperating with utilization management guidelines
7. Advising UniCare of catastrophic or special needs cases

Note: Change of PCP is effective the 1st day of the month after the member makes the request. PCP changes are not made retroactively.

Closing Panel to New Patients. Network PCPs must notify UniCare in writing at least 60 days prior to closing their panel to new patients/members and not less than 30 days prior to the date when the practice will again be open to new patients. A physician may not close his/her practice unless the practice is closed to all new patients and upon reopening the practice, a physician shall accept UniCare members on the same basis as any other new patients. Regardless of whether a practice is closed to new patients, a participating physician shall continue to offer care to an existing patient until the patient has transitioned to another physician.

Dismissing Members from Panel. If a physician is unable to maintain a satisfactory physician–patient relationship due to noncompliance or disruptive conduct of a member, the physician should notify Network Services in writing, stating the reasons for dismissal. Discharge of a patient may not be based on patterns of utilization or diagnosis. UniCare will work with physicians to resolve concerns or may assist in the transfer care to another PCP. Until the transfer of a patient, however, the PCP must continue to render medical services to the member.
Participating SCP Responsibilities
1. Communicate with the PCP regarding services rendered, results, reports and recommendations.
2. Advise UniCare of catastrophic or special need cases.
3. Provide appropriate health education for members.

Network Utilization
Independently contracted network physicians must use the services of independently contracted network hospitals with which they are affiliated and of other network physicians unless Medical Management has approved the services of non-participating providers. Call the number on the member’s ID card to request approval.

Network Participation Status Changes
Change in status
- Termination of participation with UniCare. Notify UniCare in writing 90 days prior to termination.
- Restrictions, changes and/or sanctions in licensing. Notify UniCare in writing immediately.
- Change in liability insurance. Notify UniCare in writing immediately.
- Change in business address/location/phone/fax. Notify UniCare in writing immediately.
- Change of ownership of practice. Notify UniCare in writing immediately.
- Change of Tax ID and/or billing information. Notify UniCare in writing immediately.
- Leave of Absence. Notify UniCare in writing 90 days prior to leave and immediately upon return.

Changes to Practice
Notify UniCare Network Services of any additions or terminations to the practice.

   New physicians: Notify UniCare in writing immediately. New physicians must meet UniCare’s credentialing requirements before they can see UniCare members.

   Terminating physicians: Notify UniCare in writing 90 days prior to date of termination.

   Demographic Changes: Notify UniCare immediately in writing of any change of address or telephone number.
Office Appointment Availability/Accessibility Standards

Availability and accessibility standards are monitored through office site visits, investigation of member complaints and periodic surveys.

**Availability**
- Emergency care: Immediate
- Urgent care: Within 24 hours
- Routine care: Within 2 weeks
- (Includes follow-up appointments for chronic conditions, non-urgent medical exams, well child visits and immunizations.)
- Initial prenatal visit: Within 2 weeks
- Complete physical exam: Within 8 weeks
- Newborn visit: Schedule at birth within 2 weeks

**Accessibility**
- 24-hour coverage (includes answering service or paging system after hours)
- Vacation coverage

**Covering Physicians**
Physicians are encouraged to arrange cross-coverage arrangements with UniCare Health Plan of the Midwest contracted physicians. If the covering physician is not contracted with UniCare, the network physician must obtain agreement from the non-contracted physician to abide by the terms of the Participating Provider Agreement including fee schedule, protocols and prior authorization requirements.

**Medical Emergencies**
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

**Authorizing Emergency Services.** Members are advised to call their PCPs whenever they are reasonably able. The PCP should
- determine whether the situation meets the emergency criteria given above and
- authorize Emergency Room care or
- instruct the enrollee how to receive appropriate care.

**Physician Administrative Complaint and Appeal Process**
Network physicians may discuss concerns about UniCare with the UniCare Medical Director or with Network Services. Written complaints may be submitted to UniCare at the address on the back of the member’s ID card.

A UniCare representative will make every attempt to resolve the issue within 30 business days. Once an issue is resolved, UniCare will communicate in writing to the physician. If the physician is not satisfied with the resolution, UniCare will provide information about the appeal process.
Members

Member Rights
1. To be treated with respect and recognition of their dignity and personal privacy.
2. To receive advice or assistance in a prompt, courteous, and responsible manner.
3. To be informed of their diagnosis, treatment, and prognosis in terms that they understand.
4. To be provided with information about their health care plan, the network physicians, hospitals and other health care professionals providing care.
5. To select a primary care physician and to change their primary care physician for any reason.
6. To receive prompt and appropriate treatment for physical or emotional disorders and disabilities in the least restrictive environment necessary for the treatment, and remain free from unnecessary or excessive medication.
7. To participate in decisions involving their medical care. They should receive enough information to enable them to make an informed decision before they receive any recommended treatment. The information should include the specific procedure or treatment and associated risks, as well as medical alternatives regardless of cost or benefit coverage.
8. To refuse treatment and to be informed of the probable consequences of their actions.
9. To be certain their health records are kept confidential except when disclosure is required by law or permitted in writing by them. With adequate notice, they have the right to review their medical records with their primary care physician.
10. To receive appropriate information so that they may give informed, voluntary consent to participate in experimental research. However, experimental and investigation procedures are not covered under their plan.
11. To receive guidance and recommendations for additional medical care when coverage ends.
12. To receive information on early hospital discharge and the follow-up care, rehabilitation, and living arrangements that are available after they are released from the hospital.
13. To have their guardian, next of kin, or legally authorized person exercise their rights on their behalf if their medical condition makes them incapable of understanding or exercising their rights.
14. To express a complaint about UniCare HMO or care they have received and to receive a response to the complaint within a reasonable period of time.
Member Responsibilities
1) To have read their Member Handbook and Certificate and know their plan benefits.
2) To coordinate their care through their primary care physician.
3) To treat all UniCare HMO and health care provider personnel and other members respectfuflly and courteously.
4) To keep scheduled appointments or give adequate notice of delay or cancellation.
5) To pay any applicable copayments at the time services are rendered.
6) To express their opinions, concerns, or complaints in a constructive manner to the appropriate people within UniCare HMO or the health care network.
7) For their medical care, the responsibility includes:
   - To communicate openly with the physician and the treatment staff. If they have questions or disagree with the treatment plan, they have the responsibility to discuss their concerns with the treatment staff and make certain they understand the explanations and instructions.
   - To follow the guidelines given by the treatment staff and to consider the potential health consequences if they refuse to comply.
   - To be honest and complete when providing information to the treatment staff.
   - To understand what medications they are taking and whether follow-up care is needed.
UniCare’s comprehensive quality improvement program supports the provision of quality care and enhanced service processes. The program is regularly monitored by independently contracted physicians as well as senior staff and is based on a systematic, objective and multidisciplinary approach.

To obtain a more detailed description of the quality improvement program’s goals, processes and outcomes as they relate to member care and service, contact:

Director of Quality Management
UniCare
233 S. Wacker Dr. Suite 3900
Chicago, IL 60606

**Medical Record Standards for UniCare Health Plans of the Midwest**

UniCare requires participating providers in the independently contracted network to establish and maintain medical records in a manner that is current, detailed and organized; that fosters effective and confidential patient care; and is conducive to quality review. Below is a brief summary of the standards that UniCare requires of its independently contracted providers.

**Confidentiality Standards**
- Provider offices have a formal medical record confidentiality policy.
- Medical records are protected from public access both within permanent file areas and during normal office operations.
- Medical records are maintained in a manner that is consistent with applicable laws and regulations addressing confidentiality and with UniCare Provider Agreement requirements that address the confidentiality of patient medical records.

**Documentation Standards**
- Each page (front and back sides) of the medical record contains the patient's name.
- All entries in the medical record are indelibly added, dated and contain the author's identification, which may be a handwritten signature, unique electronic identifier or initials.
- The medical record is legible to someone other than the writer. A second reviewer examines any record judged to be illegible.
- Chronic medical conditions of patients seen 3 or more times are indicated on a problem list.
- Medication allergies and adverse reactions are prominently noted in the medical record. If the patient has no known allergies or history of adverse reactions, this is noted in the medical record.
- Past medical history of patients seen 3 or more times is easily identified.
- Reports on consultation, lab and imaging ordered by the PCP and filed in the medical record are initialed by the PCP or other practitioner at the site to indicate they have been reviewed. If reports are presented electronically or by some other method, there is representation of review by the PCP.
- There is an explicit notation by the PCP of follow-up plans if consultations ordered by the PCP indicate a need for follow-up care or treatment.
- There is an explicit notation by the PCP of follow-up plans if results of lab and imaging studies ordered by the PCP were abnormal.
Organization Standards
Practice offices maintain for each patient an individual medical record that is systematically organized, easily retrievable for office visits and telephone inquiries and includes, at a minimum, areas for recording and/or filing the following information:
- Patient identifying information
- Patient history
- Problem list
- Current medications
- Medication allergies and adverse reactions
- Test results, operative notes, consultations, ancillary service reports, and discharge summaries
- Physician visit notes and follow-up instructions
- Immunization history
- Growth chart (pediatrics)
- Prenatal visits (obstetrician/gynecologist)

Appointment Standards
UniCare HMO has established the following standards for scheduling appointments with primary care physicians (PCPs):
- Emergency care: Immediate
- Urgent care: Within 24 hours
- Routine care: Within 2 weeks (includes follow-up appointments for chronic conditions, non-urgent medical exams, well child visits and immunizations)
- Initial prenatal visit: Within 2 weeks
- Complete physical exam: Within 8 weeks
- Newborn visit: Schedule within two weeks of birth

Accessibility Standards
- 24-hour coverage (includes answering service or paging system after hours)
- Vacation coverage

Members are expected to schedule all routine visits in advance and are informed of this in the member handbook. UniCare monitors PCP compliance with these standards through member complaints, office site visits and telephone audits.

Health Improvement Programs and Clinical Guidelines
UniCare provides Condition Management programs for diabetes, asthma, COPD, coronary artery disease and congestive heart failure (CHF). These programs are designed to help members develop the self-management skills of members who are living with a chronic disease by educating them to improve their health status and prevent complications. UniCare offers assistance to individuals who are managing their chronic conditions in conjunction with the treatment they are receiving from their doctors. These are voluntary programs and the final decision about treatment remains with the patient and his/her doctor. These programs are based on guidelines that have been developed by nationally recognized organizations and reviewed and updated annually. Revisions are reviewed and approved by the Clinical Quality Improvement Committee (CQIC), which includes network practitioners. Please see www.unicare.com, “News & Updates,” for the most recent approved clinical guidelines.
These guidelines are for educational purposes only, and are not the practice of medicine, or a substitute for independent medical judgment. Physicians are instructed to exercise their own independent medical judgment based upon each patient’s health care needs. To obtain a copy of the approved clinical guidelines for diabetes, asthma, COPD, coronary artery disease or CHF, call the Quality Management Department at (312) 234-7315.

Patient Safety
UniCare HMO evaluates, monitors and promotes patient safety through the distribution of information to members and practitioners about clinical safety issues, and by focusing on safety via a number of its quality improvement activities. These activities include the medical record documentation survey, monitoring continuity and coordination of care and monitoring pharmaceutical prescribing practices. In addition, the health plan supports the initiatives developed by the Leapfrog Group. The Leapfrog Group, sponsored by a national association of Fortune 500 chief executive officers, has developed initiatives to improve and promote patient safety, such as using computer physician order entry systems, focusing on evidence-based hospital referrals and improving the quality of ICU physician staffing. UniCare encourages its hospital providers to participate in the Leapfrog Group’s efforts. More information regarding the Leapfrog Group and patient safety can be obtained at www.leapfroggroup.org.

New Technology Assessment
UniCare regularly reviews new technologies through a Medical Policy and Technology Assessment Committee. This national group of practitioners and experts, in conjunction with local quality committees, examines new diagnostic and treatment methods. Using an evidence-based approach to the medical literature, these groups review information available to the public to determine if the modalities under review are approved by the appropriate regulatory bodies, are safe and effective, improve overall health outcomes and are as beneficial as established alternatives. When new technologies meet these criteria, they are eligible to become covered benefits. To view further details of this process online, go to the UniCare website at unicare.com. If you have questions about this process, please send inquiries to: UniCare, Medical Director, Medical Operations Management, 233 S. Wacker Dr., Suite 3900, Chicago, IL 60606.
HEDIS/CAHPS
The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed by the National Committee for Quality Assurance (NCQA) with the goal of ensuring that employers and consumers have the information they need to make a reliable comparison of the performance of managed health care plans. HEDIS performance measures are related to significant public health issues such as childhood immunizations, breast and cervical cancer screenings, high blood pressure, comprehensive diabetes care, cholesterol management and prenatal and postpartum care.

UniCare also conducts a standardized survey of consumers’ experiences that evaluates overall satisfaction with plan performance in the areas of customer service, access to care and claims processing. The Consumer Assessment of Health Plan Survey (CAHPS) is a standardized satisfaction survey developed by NCQA. The adult member satisfaction survey data collection and analysis are integral parts of the continuous quality improvement process utilized by UniCare Health Plans of the Midwest. Results are used to analyze trends, identify barriers and develop actions for improvement.

Communication Between Medical and Behavioral Health Providers
UniCare promotes the continuity and coordination of care between independently contracted medical and behavioral health providers to ensure that members will receive optimal treatment for concurrent medical and psychiatric disorders. In order to provide comprehensive care, the practitioners must exchange information about the members’ diagnoses and treatment plans in a timely, effective and confidential manner. The member’s written consent is required to authorize the information exchange between the practitioners.

When a member is referred for behavioral health services by a UniCare provider, or when the provider becomes aware that a member has self-referred for services, the provider can discuss the importance of the member’s consent to communication between the UniCare and behavioral health providers. A sample consent form is available on the UniCare provider website, www.unicare.com, in the News & Updates section.

Sentinel Event and Clinical Complaint Review Process
The Quality Management department receives cases referred for potential quality of care issues. Cases are reviewed by registered nurses and may be referred to the Peer Review Subcommittee for corrective action, if necessary. The provider is notified in writing of the potential quality issue, is given the opportunity to provide additional information and is informed in writing of the outcome of the subcommittee review. Adverse review results are included in the practitioner/provider credentialing profiles and are considered during the recredentialing process.

Sentinel Events Review
Identified through the utilization management process, a sentinel event is an occurrence in the inpatient, outpatient or ambulatory setting that is not a usual or anticipated consequence of the patient’s disease process or treatment regimen. UniCare will request pertinent inpatient and/or outpatient medical records.
Clinical Complaints Evaluation
Clinical complaints are defined as alleged quality of care issues involving an inpatient, outpatient or ambulatory care site; provider’s office; or contracted agency and may involve access to care, patient/family communication, referral process, assessment, treatment and professional behavior.
A UniCare HMO member or a UniCare independently contracted provider may initiate a clinical complaint.
The Health Insurance Portability and Accountability Act (HIPAA) was passed into law with the goal 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 coverage, 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 make every effort to be compliant with all requirements.

The UniCare website at www.unicare.com provides extensive information about rules governing coding, data transmission and patient privacy.