## UniCare
### 2009 Hospital and Ambulatory Surgery Center Operations Manual

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Section 1: Introduction
UniCare Hospital/ASC Operations Manual

UniCare is a family of companies that designs and administers health benefit plans to members throughout the United States. The UniCare companies (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 in TX only] are operating subsidiaries of WellPoint Inc., one of the country’s largest publicly traded health care companies.

UniCare is committed to working with hospitals and ambulatory surgery centers (ASC) to deliver quality care to members. Ambulatory Surgery Centers include hospital outpatient facilities and freestanding ambulatory surgery centers. The UniCare Hospital and Ambulatory Surgical Center Operations Manual is an integral part of this commitment, providing information about key contractual terms, products, eligibility, admissions procedures and related authorization requirements, claims submission and medical management guidelines. In those instances where information in this manual differs from that in the UniCare Agreement, the Agreement takes precedence over the manual.

Disclaimer
This manual and its contents are confidential, proprietary information of UniCare. The provider agrees not to disclose such information, to protect and hold the information confidential and to use this information solely for the purposes set forth in the UniCare Agreement.

Glossary of Terms
There are many terms used throughout this manual to describe contracted providers, organizations and specialized services that relate to UniCare’s benefit plans and Agreements. In the case that any definition conflicts with the Benefit Agreement or any applicable law or regulation, the applicable law or regulation shall control, next the Benefit Agreement and finally the definition contained below.

Affiliate(s). A corporation or other organization owned or controlled, either directly or through parent or subsidiary corporations, by UniCare, or under common control with UniCare, which does not have a separate contract with hospital or ambulatory surgery center.

Benefit Agreement(s). A written agreement entered into between UniCare and a group or individual pursuant to which UniCare pays or reimburses for health care expenses, provides or administers health care benefits or otherwise pays or arranges for the payment of benefits established by UniCare or by persons or entities utilizing the UniCare Provider Network, including Affiliates or Other Payors, pursuant to an agreement with UniCare. When such Benefit Agreement is between a group or individual and an Affiliate or Other Payor, hospital or ambulatory surgical center shall owe the obligations of its UniCare Agreement to such Affiliate or Other Payor and look to such Affiliate or Other Payor for the performance of obligations owed to hospital or ambulatory surgical center under this Agreement.

Case Management. A process of arranging, negotiating and coordinating benefits and medically appropriate care in a coordinated manner during prolonged periods of intensive medical care, including the use of benefit substitution, based upon the member’s Benefit Agreement.
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Coinsurance. The amount, as determined under the terms of the applicable Benefit Agreement, as the portion of the allowable expense for Covered Services that a Member is required to pay to the Participating Provider rendering such services. The definition of Coinsurance includes, but is not limited to, copayments, deductibles and any penalties for which Member is liable in having failed to follow the terms of the Benefit Agreement.

Coordination of Benefits. The method of determining primary responsibility for paying Covered Services received under the terms of the applicable Benefit Agreement or insurance policy or other health care program or plan, and applicable law and regulations, when more than one payor may have liability for payment for services received by a Member.

Covered Billed Charges. Charges billed by a hospital or ambulatory surgery center at its normal rates under its charge master for covered services. Covered Billed Charges shall not exceed the usual charge made to persons in the same general locality for similar services or supplies.

Covered Services. Medically Necessary health care services that are covered by the terms of a Benefit Agreement.

Day of Service. A measure of time during which a Member receives Covered Services and which occurs when a Member occupies a bed as of 12:00 midnight or when a Member is admitted and discharged within the same day, provided that such admission and discharge are not within 24 hours of a prior discharge.

Emergency. The following definition applies to Illinois and Mid-Atlantic. A sudden onset of a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including without limitation, sudden and unexpected severe pain) such that a prudent layperson, possessing average knowledge of medicine and health may reasonably believe that the absence of immediate medical or psychiatric attention could reasonably result in any of the following:

- Placing the patient’s health in serious jeopardy
- Serious impairment to bodily functions
- Other serious medical or psychiatric consequences, or
- Serious an/or permanent dysfunction of any body organ or part.

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

Emergency. The following definition applies to Texas. Health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual’s condition, sickness or injury is of such a nature that failure to get immediate medical care could

- Place the individual’s health in serious jeopardy
- Result in serious impairment to bodily functions
- Result in serious dysfunction of a bodily organ or part
- Result in serious disfigurement, or
- For a pregnant woman, result in serious jeopardy to the health of the fetus.

In the case that this meaning conflicts with applicable law or regulations such law or regulation shall control.
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Medically Necessary (Medical Necessity). Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are
1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
3. not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

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

Member. An individual who is eligible and covered under a Benefit Agreement.

Other Payors. Persons or entities utilizing the UniCare Provider Network pursuant to an agreement with UniCare or its Affiliates, including but not limited to, Affiliates, self-administered or self-insured programs providing health care benefits or employers.

Participating Ambulatory Surgical Center. An ambulatory surgery center that has entered into an Agreement with UniCare to provide covered services as a Participating Provider.

Participating Hospital. A hospital that has entered into an Agreement with UniCare to provide Covered Services as a Participating Provider.

Participating Physician. A physician who has entered into an Agreement with UniCare to provide Covered Services as a Participating Provider.

Participating Provider. A hospital, ambulatory surgery center or other institutional provider or health facility, ancillary provider, physician, licensed practitioner, medical group, independent practice association or similar entity that has entered into an Agreement with UniCare to provide Covered Services.

Participating 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.

Per Diem. A measure of fixed payment for a Day of Service.

Preventable Adverse Events. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients. These events are measurable and can often result in death, loss of body part, disability or more than transient loss of a body function.

UniCare Provider Network. The network of Participating Providers.
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Utilization Review. Functions, including Case Management, performed by UniCare, Other Payors or an entity acting on behalf of UniCare or an Other Payor that has been duly authorized and/or licensed, as applicable, as a utilization review agent to review and determine whether Covered Services provided, or to be provided, were or are Medically Necessary.

Working Day. Any day, Monday through Friday, excluding legal holidays.
Leapfrog
UniCare supports the work of The Leapfrog Group, which is comprised of employers, business coalitions and health plans across the nation that buy and provide health care benefits. Leapfrog’s goal is to reduce preventable medical mistakes through improvements in health care safety and to provide consumers with information to make informed health care decisions. UniCare strongly encourages contracted hospitals to participate in the Leapfrog Group’s online survey of patient safety practices, at www.leapfroggroup.org. The survey results offer members information about facilities in their area and helps them to find one suited to their needs.

Following are some recommendations from the health care industry and patient safety groups.

- Know your patients’ rights and responsibilities to voice concerns, receive clear instructions and be part of discussions regarding their treatment and health.
- Improve communication among caregivers by implementing a “read back” process for telephone orders or receiving critical test results.
- Ensure accuracy of patient identification by using at least two patient identifiers.
- Check the safety and accuracy of supplies through detailed records and organized storage procedures.

Preventable Adverse Events
The Centers for Medicare and Medicaid Services (CMS) and many national organizations like Leapfrog have focused attention on the identification of Preventable Adverse Events (PAEs). Preventable Adverse Events are identified as errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients. These events are measurable and can often result in death, loss of body part, disability or more than transient loss of a body function.

Effective October 1, 2008, UniCare implemented reimbursement policies for certain PAEs. The focus is two-fold:

- To encourage hospitals to adopt appropriate processes, technologies and strategies to prevent these events, and
- To modify reimbursement to help protect our members from the costs associated with preventable events.

UniCare will not reimburse for the following three events:
1. Surgery performed on the wrong body part
2. Surgery performed on the wrong patient
3. Wrong surgical procedure performed on a patient

UniCare may implement an action plan and/or reimbursement modification if any of the following occurs during a hospitalization:
1. Retention of a foreign object in a patient after surgery or other procedure
2. Air embolism or blockage
3. Blood incompatibility
4. Catheter-associated urinary tract infection
5. Decubitus (pressure ulcer)
6. Vascular catheter-associated infection
7. Surgical site infection (mediastinitis after coronary artery bypass graft (CABG))
Confirming Eligibility

To confirm a member’s eligibility or to obtain benefit information, coverage limitations and/or exclusions under a UniCare plan, call the toll-free Customer Service number indicated on the member’s identification card or go to http://accesspoint.unicare.com. Confirmation of eligibility does not guarantee payment for services rendered. If the member’s plan is an HMO, the Primary Care Physician listed on the ID card must authorize services.

AccessPoint

AccessPoint is an online tool that allows providers who treat UniCare members to connect to UniCare member eligibility, benefits and claims status. The site’s extended hours, displayed on the Provider Home page, make it easy to obtain and print information outside, as well as during, normal office hours.

Go to http://accesspoint.unicare.com to request an account.

Telephone Confirmation

If the member’s ID card is not available, you may contact a UniCare representative at 877-UNICARE (877-864-2273) during regular business hours. Representatives are able to identify the member’s assigned Customer Service unit and route your call to the applicable unit.

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

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

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

UniCare relies on eligibility information provided by a third party and does not guarantee that persons identified as Members are eligible for benefits or that the services to be provided or arranged by the provider are Covered Services.

Identification Cards

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

ID cards provide the following information:

1. Member name
2. Certificate number
3. Plan(s) – e.g., Medical and/or WellPoint Pharmacy, Dental
4. Office visit copayment
5. Customer Service telephone number(s)
6. Claims mailing address(es)
7. Pre-authorization telephone number
8. (In Texas) Indication of whether the member plan is insured
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ID cards for HMO members carry the following additional information:

- Employer group number
- UniCare plan code
- Coverage code
- Primary Care Physician’s name and telephone number
- Primary Care Physician’s IPA or medical group affiliation
- Guidelines for obtaining services and reporting emergencies
Section 4: Claims Coding and Submission/Reimbursement
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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 guidelines are also included and changes will be posted to the UniCare website, www.unicare.com

Participating facilities must submit claims within the deadline established in the Agreement with UniCare.

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 and UB-92 Editor. 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, HCPCS Codes, CPT Codes, ICD-9-CM Diagnostic and Procedural Codes and UB92 Revenue Codes. Additional sources of information include Medicare Guidelines, updated quarterly, 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 and code auditing software products. For hospital claims, UniCare also may use Milliman USA guidelines along with UniCare’s own medical policies, which are published on www.unicare.com

The claim processing system utilized by UniCare incorporates edits based on coding guidelines mentioned above and other sources as well as its own analyses of medical and technological advances.

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

Payment rates based on per diem case rates or grouper rates include, but are not limited to, the following services:

- Facility charges, including operating room, observation room and recovery room
- Laboratory services
- Radiology services
- Imaging
- Nursing and technician services (including incremental nursing)
- Medical equipment and supplies
- Drugs and biologicals
- Materials for anesthesia, including the anesthetic, casts, pins, screws, wires and splints
- Surgical dressing and supplies
- Housekeeping services
- Administration
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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.

Listed below are UniCare approved clearinghouses for hospital and ambulatory surgery center claims.

- SSI Group (800) 880-3032
- WebMD Corporation (800) 215-4730

These vendors are independent entities not affiliated with UniCare or any of its affiliates, subsidiaries or parent corporation. Direct questions regarding electronic billing to UniCare EDI Services by phone at (877) 210-4083 or by email at ediunicare@wellpoint.com.

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

Paper Claim Submission
Providers should use Universal Billing Form 92 (UB92) when submitting paper claims and UB-92 data elements for electronic claims. Claims should be submitted to the address indicated on the member’s identification card or electronically.

Claims should include
- Subscriber/member information
- Facility information, including Tax ID Number and NPI
- Referring physician information
- ICD-9 code (Primary ICD-9 code should be entered in the first diagnosis code field.)
- CPT/HCPCS code (HCPCS codes required for all laboratory, radiology and diagnostic services. HCPCS codes must include modifier component, when applicable.)
- Revenue code (Required for all line items billed.)

Additional requirements:
1. When services begin before and extend beyond December 31, the claims should be split at calendar year end.
2. Three-digit bill codes provide type of facility, billing classification and frequency information.
3. Itemization is required when services are performed on the same date of service.
4. Newborn “well baby” charges should be submitted with the mother’s charges on the same claim.
5. Medical records may be requested.
6. Outpatient therapies (physical, occupational, speech and respiratory therapy)
   Claims for outpatient therapies should include the date of service as a separate line item for each therapy rendered.

   Required revenue codes:
   - Physical therapy 42X or 977
   - Occupational therapy 43 X or 976
   - Speech therapy 44X or 979
   - Respiratory therapy 41X or 976 (Follow billing requirements in outpatient laboratory, radiology and diagnostic services section of UB92 manual for ECG, EEG, EKG.)
Claims Authorizations
The claims system recognizes claims requiring authorization based on the type of service rendered. When a claim requiring prior 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 Certificate of Coverage. If an authorization is not found, the claim may be reviewed retrospectively for medical necessity. UniCare has published medical policies on UniCare’s website www.unicare.com Claims may be denied for failure to obtain authorization when required. Call the Customer Service number on the member’s ID card to determine if service(s) require prior authorization.

Utilization management benefit determinations made by UniCare are solely for determining whether the medical and/or hospital services meet the medical necessity criteria set forth in the member’s Certificate of Coverage. Benefit authorization does not guarantee the payment of a claim. The final decision whether to proceed with any treatment or services rests with the patient and physician.

Claims Filing Deadlines
Hospitals and ASCs must submit claims to UniCare within 120 days from the date of discharge or as required by the terms of the participating Agreement for inpatient and outpatient claims. Failure to comply with contractual requirements for timely submission of claims may result in claim denials. In the event that a claim is denied for failure to comply, the member is to be held harmless (i.e., not billed) in this instance. Instructions for appeal will accompany the denial. For claims that involve coordinating benefits with another carrier or Medicare, the date of the other carrier’s explanation of benefits or Medicare’s explanation of benefits is used for determining the eligible submission period. Accurate and complete claims that are not contested by UniCare are processed within 30 days of receipt.
Member Liability
The only charges for which the member may be liable and may be billed by a UniCare Participating Provider are

1. deductibles, copayments and coinsurance amounts required by the member’s benefit agreement;
2. medical services not covered by the member’s benefit agreement if agreed to in advance in writing by the member;
3. services prospectively denied for lack of medical necessity if agreed to in advance in writing by the member.

UniCare plan designs generally 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 copayment or coinsurance for services received after all required deductibles have been satisfied. While copayments and deductibles may be collected at the time the services are rendered, UniCare recommends billing the coinsurance amount upon receipt of the UniCare Explanation of Benefits.

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

Third Party Liability/Workers Compensation
Third Party Liability occurs when a person or entity other than the UniCare member is 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 a member may make.

UniCare may have a right under the member’s benefit agreement to seek reimbursement for the benefits it pays for this treatment from a third party or third party’s insurer. However, neither this right to reimbursement nor the fact that UniCare may have been reimbursed in whole or in part for a particular benefits payment renders the medical services noncovered under the member’s agreement.

Coordination of Benefits (COB)
UniCare will coordinate benefits to determine responsibility for payment of eligible expenses when there is more than one insurer providing coverage to the member. Primary and secondary coverage is governed by Prime Carrier Rules or as set forth in the member’s certificate of coverage. UniCare’s payment will not exceed the maximum UniCare allowable amount, total charges or the member’s responsibility for covered services, whichever is less. The COB discount will be applied to the secondary payment when applicable.

These rules do not apply to
- Non-group policies
- Auto insurance policies
- Medicaid
- TRICARE/CHAMPVA
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If the member’s illness, injury or other condition is the legal responsibility of a third party, the third party may be responsible for the associated costs. UniCare may be entitled to reimbursement from the member from any settlement made on behalf of the member.

Fee Schedule, Reimbursement, Coding and Bundling Guidelines
As outlined in the UniCare Agreement, once a claim is determined to be payable, the full payment is the negotiated rate or the hospital’s or ASC’s billed charges, whichever is lower, from which the member’s liability, described above, is subtracted.

Negotiated Reimbursement
The UniCare pricing system electronically adjudicates the appropriate fee according to national standards and UniCare claim processing policies. UniCare participating providers may not bill members for charges in excess of the negotiated reimbursement for covered services.

UniCare’s pricing methods are based on per diem rates, global rates, per visit rates and negotiated fee schedules.

Per diem rate is an all-inclusive fee for each approved day of service in a hospital, which includes nursing and nursing incremental charges. Some of the services to which the per diem applies are inpatient services for acute care, sub-acute care, psychiatric and chemical dependency services. A per diem rate applies when a member is in the hospital as of twelve o’clock midnight or as defined by the Agreement.

Global rate is an all-inclusive rate to cover hospital expenses for a particular service. A global rate may apply to maternity, outpatient surgery, outpatient psychiatric and chemical dependency services, emergency room and urgent care visits and transplant services.

Per visit rate applies to a single date for outpatient services. The per visit rate applies to outpatient therapy (physical, respiratory, occupational and speech therapy) and outpatient infusion therapy. The per visit rate includes all services incidental to the outpatient visit, except outpatient infusion therapy pharmaceuticals, which are reimbursed separately. J-codes are required when billing for outpatient infusion therapy pharmaceuticals. Refer to the most current HCPCS manual for a complete listing of the infusion therapy agents found in the J-code section.

Negotiated fee schedules are rates established for laboratory, radiology and diagnostic services. These service categories require HCPCS/CPT codes and (if required) a technical component modifier. Laboratory and radiology services combined with physical, respiratory, occupational, speech and infusion therapy are priced separately. Claims are adjudicated per date of service.

HCPCS, ICD, CPT, DRG, UB92 Revenue Codes
Current HCPCS, ICD and CPT coding manuals must be used when coding claims, since many changes are made to these codes annually. These manuals may be purchased at any technical book store or by calling

HCPCS: (800) 633-7467  ICD: (800) 765-6588
CPT: (800) 621-8335  DRG: (800) 464-3649
UB92: (800) 633-9281
Bill Codes
All claims must include the appropriate type of bill code as identified in standard UB92 coding guidelines. The three-digit bill code provides type of facility, billing classification and frequency.

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 surgery procedure with the highest UniCare allowable dollar amount 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 surgery 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.

When multiple surgeries are billed and none of the surgery services is identified as incidental or ‘as is’ procedures, minor procedures are paid at a reduced rate. The reduction for all multiple surgery claims normally is as follows:

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<th>Procedure</th>
<th>Reduction</th>
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<tr>
<td>Major</td>
<td>100% normally</td>
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<tr>
<td>Second</td>
<td>up to 50%</td>
</tr>
<tr>
<td>Third</td>
<td>up to 50%</td>
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<tr>
<td>Fourth</td>
<td>up to 50%</td>
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<td>Fifth</td>
<td>up to 50%</td>
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Bilateral procedures 150% (normally) of bilateral procedure negotiated rate or covered billed charges, whichever is lower. Additional bilateral procedures are reimbursed at the lesser of covered billed charges or 75% of bilateral procedure negotiated rate.

Outpatient Surgeries
UniCare reimburses for outpatient surgery or scopic procedures (i.e., procedures performed on an outpatient basis and not in conjunction with an admission), less any applicable copayments. The ASC fee schedule, grouper numbers 1 – 9, is established by UniCare and is based on internal and external data. Each grouper consists of surgical CPT codes that are associated based on resource, skill and complexity.
UniCare reserves the right to update the Outpatient Surgery Groups based on introduction of new codes, deletion of codes or changes in technology. UniCare also reserves the right to determine all classification levels.

**Additional Information**

1. Major and minor surgeries are priced line-by-line based on the UniCare allowed amount or as otherwise stated in the Agreement and not by the amount of billed charges of the procedure on the claim.
2. The Medical Review Unit (MRU) will 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.)

**Reimbursement for HCPCS Level II 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 will be denied as not payable, and the facility may not bill the member. These drugs 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.

**Common Reasons for Rejected and Returned Claims**
Occasionally, UniCare must 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:

- **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.
- **Incomplete data submitted.** Refer to the UB-92 Coding Manual.
- **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.
- **Missing itemizations for drugs and infusion therapy.**
- **CPT Code 99070.** Valid HCPCS code should be submitted.
Remittance Advice
UniCare’s Remittance Advice (RA) is a reimbursement report for hospitals and other facilities that consists of detailed line information and a payment summary. RAs are issued electronically or in paper form. Eligible payments are accumulated on the same issue date for paper RAs. The resulting check represents benefits paid for multiple patients, service dates and claims.

The hospital RA contains three page formats:
1. Provider check
2. Detailed line information for each patient; there may be multiple pages of this information.
3. Payment summary

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. Subjit details to

UniCare
Attention: Appeals
PO Box 4458
Chicago, Illinois 60680

UniCare will provide a response within 60 days of receipt of the appeal.
UniCare’s Medical Management Department works with independently contracted network hospitals, ambulatory surgery centers and 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. Member benefit plans describe specific services that are not eligible for benefits. Benefit agreements may limit or exclude a service that is medically necessary. **Nevertheless, all decisions regarding care or treatment remain with the member and physician, whether or not the service is a covered expense.**

UniCare’s medical management benefit decision-making is based upon the terms set forth in the member’s certificate of coverage. UniCare does not reward any staff for issuing non-authorizations and does not offer incentives to encourage inappropriate underutilization.

Case Managers on the Medical Management staff are available to discuss care and benefit options for catastrophic cases as well as care that may require multidisciplinary or community services. These options can maximize benefits for members, facilities and physicians.

**Medical Management Process**

The medical management staff, comprised of M.D.s and R.N.s, determines benefits according to the criteria for medical necessity set forth in the member’s certificate of coverage. These benefit 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 and surgical care. Following the benefit review determination, the treating provider will receive a letter advising that the service was certified or not certified for benefits. Members will also receive a letter if the service is not certified.
Preauthorization

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

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

In Texas

- Medical Management will respond within three (3) calendar days of receipt of request for non-urgent authorizations and
- Within one (1) hour of receipt of request for urgent care

The following information is required when requesting benefit authorization:

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

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

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

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

Inpatient Care
Preauthorization of benefits is required for any elective (non-urgent, non-emergent) admission to a hospital or facility, including those for the following:

- medical and surgical services including normal vaginal and c-section deliveries
- skilled nursing services (including Skilled Nursing Facility)
- psychiatric and substance abuse services (behavioral/mental health)

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

Outpatient/Ambulatory Care
Many outpatient services performed in hospital, ambulatory surgical and physician office settings require benefit preauthorization. A complete list of these services may vary by member benefit plan but may include the services listed below. Call Customer Service to determine if a service or procedure requires benefit preauthorization.

- Surgical procedures (such as breast surgery, surgery of head/face/nose/mouth/throat/external ears and eyelids, gastric bypass, abdominoplasty/panniculectomy, lipectomy/liposuction, injection of collagen, vein stripping/injection of sclerosing agents, cochlear implants, etc.)
- Home health care
- Diagnostic procedures (CT/CTA scans, MRI/MRA scans, nuclear cardiology studies, PET scans)

**Note:** **High-tech radiology procedures** require an RQI (Radiology Quality Initiative) number, which serves the same purpose as the authorization number provided through UniCare’s review program.

The provider who orders the service should obtain an RQI number prior to scheduling the outpatient service by calling the Customer Service telephone number on the member’s ID card or by linking to [www.americanimaging.net](http://www.americanimaging.net) at [www.unicare.com](http://www.unicare.com) or accesspoint.unicare.com to enter relevant information online. In most cases providers will obtain RQI numbers immediately.

The provider who performs imaging exams can confirm that an RQI number was issued by linking to [www.americanimaging.net](http://www.americanimaging.net) at [www.unicare.com](http://www.unicare.com) or accesspoint.unicare.com. The site displays a list of all current RQI numbers pertinent to each facility.
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Concurrent Review
Concurrent review is necessary when the patient stay will exceed the previously approved benefits for length of stay and providers should contact Medical Management to obtain additional authorization of days.

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

Retrospective Review
Retrospective review is performed when a service was performed but was not previously certified by Medical Management. UniCare will not rescind previous authorizations except in cases of fraud, misrepresentation or where the medical records differ from the information previously provided to UniCare. Providers may request an appeal of a clinical benefit non-authorization.

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

Examples of services appropriate for case management include:
- Potential organ and bone marrow transplantation
- Ventilator dependency
- Chronic pain management programs
- Difficult post-discharge placement or post-discharge cases requiring multiple services
- High-risk obstetrics
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Appeal of Clinical Non-Authorization by Medical Management
Providers may request an appeal of a clinical benefit non-authorization for up to 180 days 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.

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

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

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

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

Note: A participating provider may not bill the member for services determined to be non-medically necessary or inappropriate under the member’s benefit plan unless the member has agreed in advance to pay these charges and UniCare has denied coverage.
Timely Notification
To ensure that information contained in UniCare’s records of participating hospitals and ASCs is current, hospitals and ASCs must promptly notify the UniCare Network Services Department of:

1. Any change in business ownership.
2. Any change in business address, or change of address of locations where services are provided.
3. Any legal or governmental action initiated against the facility, including, but not limited to, an action
4. for professional negligence which, if successful, would materially impair the facility’s ability to carry out the duties and obligations under this Agreement
5. for violation of the law
6. against any license, accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or any successor, which, if successful, would materially impair the ability of the hospital or ASC to carry out the duties and obligations of the Agreement.
7. Any other problem or situation that will impair the ability of the hospital or ASC to carry out the duties and obligations of the Agreement.
8. Any reduction or elimination of emergency services. Hospitals and ASCs must give 90-day prior notice to state and local governments, contracted health plans, and the public.

In addition, the hospital and ASC must notify UniCare at least 10 days prior to any reduction or cancellation of insurance for professional liability or comprehensive general liability.

Licensure and Credentialing
Participating hospitals and ambulatory surgery centers must be certified by Medicare, if applicable, and accredited by a recognized industry accrediting organization such as JCAHO. In addition, physicians and ancillary personnel who provide services to UniCare members must be licensed or certified to practice in accordance with all state laws, if applicable.