

Midwest Payment Policy Disclosure

I. INTRODUCTION

UniCare has created this Provider Disclosure to clarify our claims policies and procedures and help providers to interpret payments. The contents of this Provider Disclosure are effective as of 1/1/2004. Reimbursement 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. This document is not meant to supplant the terms stated in your contract with UniCare. In the event of any conflict between the terms stated in this document and your contract with UniCare, the terms of your contract will govern. Should you have questions about this document, please telephone Network Services at 800-700-0668.

This document, for use by UniCare network providers in Illinois, Indiana and Ohio, 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.-

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.

The majority of UniCare’s business utilizes claim editing software called Claim Check version 6.0, published by McKesson and updated on a semi-annual basis.

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. Please refer to the provider manual for 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.

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II. Claims Submission Requirements

Claims Address

Claims should be submitted to the address indicated on the member's identification card or electronically. The Payor Number for the electronic submission of claims is **80314**.

Provider License Number/Professional License (For Hospital Medicare ID)

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), please 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 and an institution's Medicare number on Field 51 of the UB 92. Claims submitted without a state license number may be returned or their processing may be delayed.

The state license number is not currently required for the following provider types. Practice zip code is, however, necessary to determine claim payment.

- air ambulance
- blood bank
- Christian Science Nurse
- Christian Science Practitioner
- 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

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Claims Filing Deadlines

Healthcare professionals must submit claims to UniCare as specified by the participating provider agreement or benefit plan; failure to comply 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. 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.

Claims Authorizations

The claims system recognizes claims requiring authorization based on the type of service rendered. When a claim requiring prior approval 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 will be reviewed retrospectively for medical necessity. UniCare has published medical policies on UniCare's website www.unicare.com For UniCare Health Plans of the Midwest, claims may be denied for failure to obtain authorization when required. Please call the Customer Service number on the member's ID card to determine if service(s) require prior authorization..

Utilization management benefit determinations made by UniCare are solely for determination of whether the medical and/or hospital services meet the medical necessity criteria set forth in the member's certificate of coverage. 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.

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.

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.

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 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.

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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 denied as not medically necessary 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***.

Prime Carrier Rules are 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, 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 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 the Member may make.

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 ("TIN") combination as shown on the records of the Internal Revenue Service ("IRS") 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.

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Generally, backup withholding begins when

1. A payee has been notified by UniCare that his/her name and/or TIN does not match the name and/or TIN 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's Corporate Tax Department at the following address:

4553 La Tienda
Mail Stop: T1 – 2C4
Thousand Oaks, CA 91362

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 the Corporate Tax Department at (888) 246-4893.

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.

The initial notice regarding overpayment recovery will be provided not later than the 180th day from the original claim payment date or following completion of a claim audit; a payee's failure to provide information requested in a timely manner pursuant to an audit will be considered completion of the audit. The overpayment and recovery process that will be followed is as follows:

Day 1 – Overpayment is identified; with regard to a claim audit, an overpayment will be identified 30 days after notice of completion of the audit has been provided to the provider and the provider has not submitted any refund due.

Day 3 – 1st 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 45th day from day 3). The letter will include the specific claims at issue and amounts for which a refund is due and 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 45th day from day 3). The letter will include the specific claims 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 50 – 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.

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Day 60 – If UniCare is unable to collect from future claims payments, 3rd letter will go to payee advising that UniCare will refer the overpayment to external collections in an effort to recover.

Day 90 – If UniCare is unable to collect from future claims payments or through other internal collection methods, 4th letter will go to payee advising that UniCare will refer the overpayment to external collections in an effort to recover.

Day 120 – UniCare begins recovery process in an effort to recover overpayment either by referral to collections vendor or other internal collection methods

If during this process the payee disagrees with the request for a refund, he/she may appeal by contacting UniCare in writing at:

UniCare Risk Management
P.O. Box 9207
Oxnard, CA 93031-9221.

In addition, UniCare Risk Management may be contacted with questions concerning overpayment recovery at 312-234-7410.

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

Reciprocity

UniCare members enrolled in other UniCare benefit agreements outside of 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.

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 accurately track calendar year deductibles and co-payment maximums.

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.

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III. 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. 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.

The following are some general UniCare claims submission and reimbursement guidelines.

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.

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Most Frequently Billed CPT Codes Not Eligible for Payment

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 99354 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.)

CPT Code 99358 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.)

CPT Code 99050 Services requested after office hours in addition to basic service. Reimbursement for the office visit will be payable. No additional charges for after-hours services will be allowed.

CPT Code 99052 Services requested between 10pm and 8am in addition to basic service.

CPT Code 99054 Services requested on Sundays and holidays in addition to basic service.

CPT 36000 Introduction of needle or intra-catheter, vein.

CPT 99080 Special reports such as insurance forms or more than the information conveyed in the usual medical communications or standard reporting forms.

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.

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The following are the most commonly used modifiers. All claims are subject to review and to the terms described above.

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 is valid only for Procedures 99201 – 99499 and does not affect the reimbursement rate.

Modifier 26 Clinical Pathology Codes: Modifier 26 is payable only when billed for select clinical pathology CPT 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 upon CMS.

Services billed without a modifier 26 are considered to be global services. UniCare does not accept “GS” as a modifier to designate global services. Claims submitted with modifier “GS” will be rejected for having an invalid modifier.

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.

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

Modifier 80 Assistant Surgeon: Claim determination is normally based upon 20% of the maximum allowable rate of the surgical procedure.

Modifier 81 Minimum assistant Surgeon: Claim determination is normally based upon 10% of the maximum allowable rate of the surgical procedure. If more than one surgery is billed for the same date of service, the claim is subject to medical review.

Modifier 82 Assistant Surgeon (when qualified resident surgeon not available): If qualified provider, the claim determination is normally based upon 20% of maximum allowable rate.

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 20% of the maximum allowable rate.

Modifier TC Technical Component: This code must be billed when a charge represents only the technical component.

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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 are 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.

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- Anesthesia services identified as qualifying circumstances (by the use of additional CPT codes 99100, 99116, 99135 and 99140).
- Anesthesia with Medical Direction (QK, QY, QK) will allow for allocation of payment between supervising Anesthesiologists and CRNA(s).
- Anesthesia physical status modifiers P1 and P2. (Modifiers P3 – P6 are normally eligible for payment in accordance with ASA guidelines.)

Anesthesia Services Often Not Eligible for Payment

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

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

- intra-arterial, CPT 36620
 - central venous, CPT 36488-36489
 - 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.
 - 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.

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- **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 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 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.

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- **‘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 surgical 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:

Major procedure *100% normally*
Second procedure *up to 50%*
Third procedure *up to 50%*
Fourth procedure *up to 50%*
Fifth procedure *up to 50%*

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 evaluate claims with
 - more than five surgical procedures during the same operative session; *or*
 - one or more unlisted proceduresDetailed 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.

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 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

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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.

Laboratory Claims

Physicians must supply laboratories with a diagnosis, correct patient information (including full name and date of birth) and appropriate billing information. This information is important to ensure that laboratories have the appropriate information to bill UniCare.

There are currently 22 Multichannel tests, also known as automated tests. If one or any combination is billed, the number of tests are counted and priced based on the total number of tests billed.

Incidental Edit

A code edit that identifies a procedure performed at the same time as a more complex primary procedure, and is clinically integral to the successful outcome of the primary procedure. The incidental procedure is not reimbursed.

Rebundling

UniCare claims systems utilize code edits that replace two or more procedure codes used to report a service with a single procedure code that represents the service.

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IV. Electronic Claims

UniCare supports claims submission via Electronic Data Interchange (“EDI”), which helps provide increased productivity, efficiency and service. Other benefits of electronic filing include

- One-address billing. **Payor identification number 80314** is the only number needed to submit claims to UniCare.
- Cleaner claims. Front-end editing permits only claims that are virtually error-free to be accepted into our system. Edits prompt for information required to process claims.
- Faster claims turnaround.
- Reduced mailing costs

What Is EDI?

Electronic Data Interchange is the computer-to-computer exchange of common business transactions over telephone lines using a standard electronic format. EDI can be compared to an electronic postal service that allows physicians, hospitals, other health care professionals and payors to exchange vital information.

How Does It Work?

A computer, modem, and telephone line enable electronic claims transmission. UniCare receives submissions from independent third party software vendors, clearinghouses and billing services that collect data.

Working with Clearinghouses

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.

ENS	(800) 541-6141
MedUnite	(800) 576-6870
Per Se Technologies	(847) 608-7000
Proxy Med	(714) 979-4467
THIN	(972) 766-5480
WebMD Corporation	(800) 215-4730

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.

You may also find useful EDI updates on the UniCare web site, www.unicare.com

V. Hard Copy Billing

Participating professional healthcare professionals who are not set up to process claims electronically are required to submit all hard copy claims on the CMS 1500 claim form (with scannable "red dropout ink"). All applicable data element blocks must be complete. If the form is incomplete, it is returned for additional information needed for processing.

Midwest Payment Policy Disclosure

VI. Common Reasons for Rejected and Returned Claims

Frequently, 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:

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, it is imperative that the records are attached 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 since it is likely that the records will not arrive in the correct department.

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.

No authorization attached to claim. When submitting claims to UniCare for payment, the Utilization Management authorization form must be attached.