

UniCare Health Plans of Texas HMO Provider Manual

Table of Contents

Section 1	<u>Introduction</u>
Section 2	<u>Quick Reference Guide</u>
Section 3	<u>Eligibility</u>
Section 4	<u>Medical Management</u>
Section 5	<u>Billing/Claims Coding and Submission</u>
Section 6	<u>Reimbursement Guidelines, Coding and Bundling</u>
Section 7	<u>Benefit Administration</u>
Section 8	<u>Physician Rights and Responsibilities</u>
Section 9	<u>Member Rights and Responsibilities</u>
Section 10	<u>Credentialing and Recredentialing</u>
Section 11	<u>Quality Management</u>
Section 12	<u>HIPAA</u>

Section 1 Introduction: UniCare Texas HMO

Introduction

UniCare is a family of companies that designs and administers health benefit plans to members throughout the United States. The UniCare companies are operating subsidiaries of WellPoint, Inc.

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.

This manual is an integral part of this commitment and provides comprehensive benefit information and administrative policies and procedures. 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 relations. Our staff supports the provider network through the contracting process and provides ongoing education to providers and their office staffs.

How To Reach Us

Houston Office 1-888-697-3790

Glossary of Terms

There are many terms used throughout this manual that describe the various products, contracted physicians, hospitals, other health care professionals, organizations, and specialized services that relate to managed care. Following is a glossary of current terms.

Affiliate(s). A corporation or other organization owned or controlled, 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 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 providers 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 the IPA.

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. Payment that a member is required to make to a Participating Provider under a Services Agreement, which is calculated as a fixed dollar payment or as a percentage of the allowed charges.

Section 1 Introduction: UniCare Texas HMO

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 or supplies that are covered under the relevant Services Agreement and any amendments or riders.

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. A health care professional who is under contract, or on whose behalf a contract has been entered into, with the IPA.

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

Medical Director. A duly licensed physician or designee who has been designated by UniCare to manage Quality Management and Medical Management responsibilities, or that physician's designee.

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, were or are medically necessary.

Medical Practice. Physician(s) or entity that is required through an Agreement 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 Agreement will control.

Medically Necessary. Services or supplies that, under the provisions of the benefit agreement, are determined by UniCare to be:

1. consistent with the symptom or diagnosis and treatment of the member's injury or illness;
2. appropriate with regard to generally accepted national standards of medical practice;
3. not solely for the convenience of a member, medical practice or participating provider;

Section 1 Introduction: UniCare Texas HMO

4. the most appropriate supply or level of services that can be safely provided to the member, and;
5. recommended by the member's Primary Care Physician and authorized by UniCare or its designee, where required according to the program operating requirements.

Member(s). An individual or eligible dependent of such individual who is enrolled for coverage and entitled to receive covered services through UniCare.

Participating Physicians, Hospitals, Other Health Care Professionals and Facilities. A 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.

Primary Care Physician. Physician or medical practice licensed to practice medicine in the field of general medicine, internal medicine, family practice or pediatrics and is a participating provider with UniCare.

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.

Services Agreement. Agreement between UniCare and an employer, insurer, labor union, trust or other organization or entity, or an individual, that specifies services to be provided to or for the benefit of, or arranged for or reimbursed to or for the benefit of members, and the terms and conditions under which those services are to be provided or reimbursed.

UniCare Health Care Professional Network. The network of participating physicians and other health care professionals.

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

HMO QUICK REFERENCE GUIDE

For your convenience, please use this “Quick Reference Guide” that contains many facts, instructions and other useful information about UniCare Health Plans of Texas.

AccessPoint

To view member eligibility, benefits, check claim status and print claim reports, Visit accesspoint.unicare.com. To obtain access click on Request an Account Online at the AccessPoint Web site.

Credentialing (800) 848-7347

Questions regarding credentialing and recredentialing.

Customer Service

To obtain claim status, member eligibility information, benefit inquiry and coverage limitations, contact the Customer Service number found on the back of the member’s ID card. You may use Customer Service’s IVR system for claim status check, referral verification and fax-back eligibility information. Helpful Hints: Please have member’s nine-digit number and your Tax ID Number ready before calling. If you do not have a copy of the ID card, a representative at 1-800-877-UniCare can direct you to the correct UniCare location.

Refer to the member’s ID card for the Customer Service phone number and claim submission address.

EDI Claims Submissions

Submit claims electronically to Payor Identification (ID) 80314.

For additional information about electronic claims submission, please contact UniCare EDI Services by phone at (877) 210-4083 or email at ediunicare@wellpoint.com. Find useful EDI updates on the UniCare web site, www.unicare.com

Eligibility

Participating IPAs and Independent PCP offices receive limited membership data on a monthly basis. Call (800) 451-0608 to use UniCare’s Interactive Voice Response (IVR) eligibility information system. Remember, accesspoint.unicare.com also provides this information.

Eye Care

Some members have routine eye care benefits. Providers may call Customer Service to determine their benefit. PCP referrals are required for visits to ophthalmologists or other specialists.

Laboratory

Laboratory services are covered under capitation. Call 800-824-6152 for drawing station locations.

Mental Health and Substance Abuse Services (800) 438-7758

APS provides mental health and substance abuse services for UniCare HMO of Texas members. Members may contact APS directly, or the PCP, specialist or any other provider may contact APS on behalf of the patient.

Network Services (888-697-3790)

Network Services associates can answer questions about contractual terms, credentialing and recredentialing and network status.

OB/GYN Direct Access

A female member may see a network OB/GYN for any obstetrical or gynecological problem, pregnancy or well-woman exam without a referral from her PCP. However, if the PCP belongs to Kelsey-Seybold, the member must select an OB/GYN from Kelsey-Seybold to be eligible for benefits. Likewise, if the member has a network PCP not associated with Kelsey-Seybold, she must select an independent network OB/GYN.

Pharmacy

Physicians should obtain benefit authorizations for non-formulary drugs by phone at (877)-727-4117 or fax (877)-809-3201. Some members may also have a mail order prescription drug benefit for maintenance drugs.

Priorauthorization

Please call 713-479-4275 or 800-510-4569 for priorauthorization of benefits. Elective inpatient admissions require priorauthorization 5 business days prior to admission. Emergency services require notification within 24 hours.

Web Site Address

Visit the UniCare website at www.unicare.com to obtain information regarding medical record documentation standards, medical policies, access to care standards, formulary, HIPAA, and many other helpful resource materials.

Section 3 Eligibility: UniCare Texas HMO

Introduction

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 for the type(s) of services rendered.

Verifying Eligibility

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

AccessPoint

AccessPoint website is an online tool that allows 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.

Providers may set up an account by going to accesspoint.unicare.com or by calling 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 current 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 physician's tax identification number ready.

To receive a written confirmation of benefits, follow the prompts for the fax-back option.

Section 3 Eligibility: UniCare Texas HMO

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 4 Medical Management: Texas HMO

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. 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 inappropriate 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 those that are

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition;
- Provided for the diagnosis or direct care and treatment of the medical condition;
- Within the standards of good medical practice of the organized medical community;
- Not primarily for the convenience of the member, the member's physician or any other medical professional; and
- Provided in the most appropriate setting.

Medical Management Process

The Medical Management staff, comprised of M.D.s and R.N.s, determines the medical necessity, 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.

Section 4 Medical Management: Texas HMO

Priorauthorization

UniCare encourages physicians' office staff to initiate priorauthorization 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 priorauthorization of treatment can also be directed to Customer Service at the telephone number on the member's ID card.

Inpatient Services that require priorauthorization

- Medical and surgical services except for normal vaginal and c-section deliveries
- Skilled nursing facility, rehabilitation center, long term acute facility
- Psychiatry/substance abuse services (please contact APS at 800-438-7758)

Outpatient Services that require priorauthorization

- Air ambulance
- Blepharoplasty
- DME rentals
- DME purchases exceeding \$1000
- Home health care
- Infertility treatment
- Injectibles: HGH for individuals > 18 years of age, Synagis, and Botox
- Physical therapy, occupational therapy and speech therapy
- Rhinoplasty
- Out of network / out of area referral
- Transplant workups

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

Section 4 Medical Management: Texas HMO

Concurrent Review

Concurrent review affirms continuing medical necessity and appropriateness of continued treatment, services or hospitalization. Review of ongoing care is required to obtain priorauthorization of days beyond the goal length of stay as well as for outpatient procedures and ongoing outpatient care that require priorauthorization.

Retrospective Review

Retrospective review is performed when services or treatment was performed without priorauthorization by the Medical Management staff. A non-authorization notice will be issued if the retrospective review determines that services are not medically necessary.

Retrospective denials of services that received priorauthorization will not be issued except in cases of fraud or misrepresentation.

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

Physicians may initiate clinical appeals of a medical management or medical necessity denial by calling the phone number on the member's ID card or on the non-authorization notice. Additional supporting documentation may be required. The UniCare physician conducting the review will not be the reviewer who made the initial determination.

If UniCare reverses the denial, a written notice will be issued. If the original determination 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 appeal, which will be sent to an external independent reviewer. Additional supporting documentation or explanations should be sent to the address on the determination letter.

The decision based on the external review is final.

Note: The provider may not bill the member for services determined to be non-medically necessary or inappropriate.

Section 4 Medical Management: Texas HMO

Medical Review of Claims

Upon receipt, complex claims are evaluated by UniCare's Medical Review Program physicians prior to processing. The medical review, supported by claims system software, focuses on procedures that may be cosmetic, benefit plan exclusions and possible CPT code and/or ICD code irregularities.

Medical reviewers may approve the billed services for processing, suggest re-coding in order to expedite payment, request additional documentation or recommend denial of payment of specific services.

Providers may request reconsideration of claims payment determinations, including re-coding recommendations. Information about the process is contained in the determination letter.

Billing/Claims Coding and Submission: UniCare Texas HMO

This section provides general billing guidelines and UniCare claim submission requirements, including information about electronic claims submission.

Participating providers must submit claims within 95 days of date of service or within the deadline established in their Agreement with UniCare and in accordance with state regulatory requirements.

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.

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 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.

Claims Submission Requirements

Claims Filing Deadlines

Participating providers must submit claims within 95 days from the date of service or within the deadline established in the Provider Agreement and according to state regulatory requirements. Failure to comply may result in claim denials. Duplicate claims may not be submitted before Day 46. “Clean claims”, as defined the state regulations, will be processed within 30 days of receipt if submitted electronically and within 45 days of receipt if submitted on paper.

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 or Medicare’s explanation of benefits is used for determining the eligible submission period. A copy of the primary carrier’s explanation of benefits form should be submitted with the claim.

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**.

Billing/Claims Coding and Submission: UniCare Texas HMO

Claims Authorizations

The claims system recognizes claims requiring authorization based on the type of service rendered. When a claim requiring priorauthorization is identified, the system searches the medical management system for the corresponding authorization. The **priorauthorization notice** is a document stating UniCare's utilization management benefit determination of medical necessity based upon the member's Certificate of Coverage. If a priorauthorization 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 priorauthorization when required. Please call the Customer Service number on the member's ID card to determine if service(s) requires priorauthorization.

Utilization management benefit terminations 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.

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 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 status report within 45 days of receipt of the appeal.

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. **See sample EOB.**

Member Liability

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

1. co-payments required by the member's Benefit Agreement and
2. medical services not covered by the member's Benefit Agreement.

To determine the member's benefits and eligibility, contact the toll-free customer service number listed on the member's identification card or go to accesspoint.unicare.com

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 practitioner must issue a prompt refund once the EOB is received.

Billing/Claims Coding and Submission: UniCare Texas HMO

Coordination of Benefits

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. UniCare payment will not exceed the maximum UniCare allowable amount, total charges or the member's responsibility for covered services, whichever is less.

These rules do not apply to

- Non-group policies
- Auto insurance policies
- Medicaid
- TRICARE/CHAMPVA

If the member's illness, injury or other condition is the legal responsibility of a third party, the third party is responsible for the associated costs. UniCare may be entitled to reimbursement from the member from any settlement made on behalf of the member.

Third Party Liability

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 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.

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.

Billing/Claims Coding and Submission: UniCare Texas HMO

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.

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 contact 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.

Billing/Claims Coding and Submission: UniCare Texas HMO

Reciprocity

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

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, including those where the patient's age or sex or the location of the service does not correspond to the diagnosis or procedure, 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.

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 coe. Conversion factors and unit values are not included. Provider-specific fee schedules may be provided on paper, CD-Rom or diskette on request.

UniCare uses these guidelines for administrative purposes such as claims processing and the development of guidelines for medical review and medical policy. Following are some general UniCare claims submission and reimbursement guidelines.

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.

Unlisted codes for home infusion therapy should be accompanied by the NDC.

Billing/Claims Coding and Submission: UniCare Texas HMO

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.

Billing/Claims Coding and Submission: UniCare Texas HMO

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.

Billing/Claims Coding and Submission: UniCare Texas HMO

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

Billing/Claims Coding and Submission: UniCare Texas HMO

- Anesthesia, given in conjunction with certain covered non-surgical procedures, when the procedure requires that the patient be kept absolutely still or is too painful to be performed without anesthesia as identified with either a modifier code or a procedure code.
- Anesthesia services identified as qualifying circumstances (by the use of additional CPT codes 99100, 99116, 99135 and 99140).
- Anesthesia with Medical Direction (QK, QY, QK) will allow for allocation of payment between supervising Anesthesiologists and CRNA(s).
- Anesthesia physical status modifiers P1 and P2. (Modifiers P3 – P6 are normally eligible for payment in accordance with ASA guidelines.)

Anesthesia Services Often Not Eligible for Payment

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

Exception: The following unusual forms of monitoring are not included in the price of 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

Billing/Claims Coding and Submission: UniCare Texas HMO

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 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 is calculated at one unit for every hour or fraction (e.g., 01 – 60 minutes = one unit; 61 – 120 minutes = two units; 121 – 180 minutes = three units, etc.)

There are no longer separate codes for vaginal delivery and cesarean delivery. If a planned vaginal delivery results in a cesarean delivery, the code for the continuous epidural, 01967, is billed with the anesthesia code for the cesarean delivery, 01968.

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 recognizes only CPT anesthesia procedure codes 00100 – 01999 when billing for anesthesia services and will not accept the practice of billing anesthesia services using surgical codes with a modifier.

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.

Anesthesia services are reimbursed with basic professional, accident rider and/or major medical benefits when billed by the anesthesiologist or CRNA.

Billing/Claims Coding and Submission: UniCare Texas HMO

Unlisted Procedure or Service

There may be services or procedures performed by physicians that are not found in the CPT code book. 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.

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.

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 procedures

Billing/Claims Coding and Submission: UniCare Texas HMO

(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.

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 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.

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.

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.

Billing/Claims Coding and Submission: UniCare Texas HMO

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 providers 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.

Most of these partners are also linked to hundreds of health care EDI networks.

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

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.

Billing/Claims Coding and Submission: UniCare Texas HMO

Claims should be submitted to the address indicated on the member's identification card and should be accompanied by the priorauthorization form if priorauthorization of the service was required. If the member's card is not available, please call 1-800-UNICARE for assistance.

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.

Reimbursement Guidelines, Coding and Bundling: UniCare Texas HMO

This section provides information about claim pricing and reimbursement, including UniCare payment and third-party liability and coordination of benefits. Procedures for recovery of excess claim payments are also included.

Clean electronic claims are processed within 30 days of receipt; clean paper claims submitted on CMS 1500 or UB 92 are processed within 30 days of receipt.

Authorization and Payment Determination

The Claims system searches the Medical Management system for priorauthorization when a claim requiring authorization is received. Claims requiring priorauthorization without priorauthorization may be reviewed retrospectively for medical necessity. *Priorauthorization of treatment or services or a determination of medical necessity does not guarantee payment.*

Explanation of Benefits (EOB)

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

- Copayment amounts required by the member's benefit agreement, and
- Medical services excluded by the member's benefit agreement if the member has agreed in advance to pay these charges.

Member Liability for Services that are Not Medically Necessary

Providers may not bill for non-medically necessary services unless the member has agreed in advance to pay these charges and UniCare has denied coverage.

Coordination of Benefits, Third Party Liability

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. UniCare payment will not exceed the maximum UniCare allowable amount, total charges or the member's responsibility for covered services, whichever is less.

These rules do not apply to

- Non-group policies
- Auto insurance policies
- Medicaid
- TRICARE/CHAMPVA

If the member's illness, injury or other condition is the legal responsibility of a third party, the third party is responsible for the associated costs. UniCare may be entitled to reimbursement from the member from any settlement made on behalf of the member.

Reimbursement Guidelines, Coding and Bundling: UniCare Texas HMO

Overpayment and Recovery

In the event of an overpayment, the benefit check payee is required to reimburse the excess payment unless the provider's Agreement states otherwise. The recovery process is outlined below.

1. UniCare notifies the payee of the overpayment and requests refund 3 days from date of claim remittance advice.
A provider may request an appeal of the claim in correspondence sent to the address on the overpayment notification.
2. Within 30 days UniCare sends a 2nd letter requesting refund. The notice states that if payment is not received within 5 days, the overpayment will be deducted from future claims payments.
3. Within 60 days of the 2nd letter, overpayment deductions from paid claims begin. If there are no deductions, 3rd letter is sent requesting refund.
4. Within 90 days if no repayment or deduction has occurred, UniCare sends a 4th and final letter requesting refund.
5. As of the 120th day, UniCare assigns the outstanding balance to a collection agency for recovery.

Benefit Administration: UniCare Texas HMO

This section explains how benefits offered in the UniCare HMO are administered. Information about eligibility, copayment collection, referral services and denials are included.

Eligibility

UniCare HMO compensates providers only for care rendered to eligible members. Since member ID cards do not carry an expiration date, please call the Customer Service number on the member's ID card to verify eligibility or go to accesspoint.unicare.com before each service. Of course, services rendered to persons who are not eligible with UniCare may be charged directly to the patient.

Office Visit Copayments

If the member's ID card indicates a copayment, refer to the sections below to help you 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 unless specified by the member's benefit plan:

- 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 (as per Medicare guidelines).
- 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.).

Point of Service

Benefits under the UniCare Point of Service plan (POS) are determined at the point of service where health care is delivered. If a member follows the HMO rules for accessing care, benefits will be paid under the HMO contract. If a member does not receive the proper authorization or receives care from physicians outside the HMO network, benefits will be paid under the contract issued by the UniCare POS plan. Members incur fewer out-of-pocket expenses by staying within the HMO network and having their primary care physician coordinate their care.

Benefit Administration: UniCare Texas HMO

Pharmacy

UniCare designed and implemented a state-of-the-art managed care pharmaceutical program that reduces and controls 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.

Network Pharmacies

UniCare members who are eligible for outpatient prescription drug benefits may have their prescriptions filled at any network pharmacy. A full listing of local network pharmacies is available on the website www.unicare.com or by calling 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 is comprised of 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 priorauthorization. If you have a question regarding whether a particular drug is included in the UniCare formulary or requires priorauthorization, consult the UniCare website (unicare.com)

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

Formulary changes will not be applied until the member's renewal date.

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.

Benefit Administration: UniCare Texas HMO

Exception Processing – Pharmacy Prior Authorization

The WellPoint Pharmacy Management (WPM) Prior Authorization Center is responsible for processing initial prior authorization requests. The WPM Prior Authorization Center is run by a pharmacist, and staffed by pharmacy technicians. They assess the information being faxed from the prescribing physician, review the completed form and determine the outcome. WellPoint Pharmacy Management can “approve,” define as “unnecessary,” or “defer” prior authorization requests. If WPM is unable to “approve” the request, they will fax the form back to the physician requesting additional information.

All pharmacy 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 or by calling the pharmacy phone number on the member’s ID card.

Diagnostic Laboratory Services

UniCare has contracted with Quest Diagnostics for a range of covered laboratory benefits and services. laboratory services. To find locations of drawing stations, call (800) 824-6152.

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.

Women’s Health Services

Female members may access network OB/GYN specialists for services without prior authorization from UniCare or their PCP. The following restrictions apply:

- Members whose PCP is affiliated with Kelsey-Sebold Clinic (KSC) must designate an OB/GYN also affiliated with KSC.
- Members whose PCP is not affiliated with Kelsey-Sebold Clinic (KSC) may designate any UniCare HMO network OB/GYN except one affiliated with KSC.

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 Health Plans of Texas contracts with APS Health to provide mental health and chemical dependency services to members.

UniCare allows members to refer directly for mental health/chemical dependency treatment. Whether a patient is referred or has gone on his/her own for care, APS will coordinate any necessary authorizations prior to rendering services.

Health care providers should call APS at 800-438-7758 to make a referral.

Commercial HMO Benefit Exclusions

Unless specifically stated otherwise in the Schedule of Health Services, the following *are not* provided under the Group Service Agreement.

1. Any care, treatment, services or supplies received outside of the service area, except for emergency health care services or as otherwise provided for under this Group Services Agreement.

Benefit Administration: UniCare Texas HMO

2. Services and supplies not provided, authorized or prescribed by or under the direction of a member's PCP, authorized specialist or authorized by the Health Plan.
3. Hearing aids, eye glasses, eye refractions, refractive eye surgery or contact lenses and the fitting thereof, except for the initial pair of eyeglasses or contact lenses up to a retail value of \$100 and needed due to cataract surgery, unless coverage for these items is expressly provided by rider to or amendment of the Group Service Agreement. This will not apply to the necessary diagnostic and follow-up care associated with hearing screenings for a child from birth through age 24 months.
4. Services and supplies for dental care, oral surgery or treatment of the teeth or periodontium, overbite or malocclusion or oral injury resulting from biting or chewing. The Health Plan will not cover dental braces, dental implants or any treatment related to the preparation or fitting of dentures, oral care and supplies or orthognathic surgery.
5. Injury or illness arising out of employment when benefits are paid or payable or the injury or illness under any Workers Compensation or Occupational Disease Act or law.
6. Custodial care or respite care.
7. Services such as private room, television, telephone, barber or beauty service, guest service and similar incidental services and supplies that are primarily for the convenience of the member.
8. Prescription and non-prescription drugs and medicines, unless expressly provided by the Group Services Agreement and any attachments or riders.
9. Any drug, biological product, device, medical treatment or procedure that is experimental or investigational.
10. Cosmetic surgery or procedures. This will not include reconstructive surgery as shown in the Schedule of Health Services. The presence of a psychological condition will not entitle a member to coverage for plastic, cosmetic or reconstructive surgery.
11. Elective termination of pregnancy.
12. Infertility treatment and services other than those appearing in the Schedule of Health Services, Item 5, Pregnancy Related Services. Infertility treatments are excluded after voluntary sterilization of either partner. Injectable drugs for the treatment of infertility are not covered. The cost of sperm and its collection are not covered by the Health Plan.
13. Services or supplies for or related to sex change services.
14. Services and supplies for or related to the reversal of elective sterilization.
15. Sexual therapy programs or treatment for sexual offenders or perpetrators of sexual or physical violence, treatment of chronic or long[term mental health disorders involving psychological or abusive behavior or psychosexual problems, including but not limited to child abuse and long-term sexual dysfunction.
16. Services and supplies that are
 - For mental retardation or a learning or behavioral disability, when such services extend beyond the period necessary for evaluation and diagnosis of the condition
 - For educational rehabilitation
 - For marriage counseling, when such services extend beyond the period necessary for short-term evaluation or crisis intervention

Benefit Administration: UniCare Texas HMO

- For treatment required by an order of a court of competent jurisdiction, including orders of parole or probation or as an alternative to same
 - For Intelligence Quotient (IQ) testing
 - Not authorized by a Primary Care Physician
17. Services and supplies for routine care and maintenance of the feet, other than medically necessary care associated with diabetes.
 18. Enrollment in a health, athletic or similar club.
 19. Treatment or surgical procedures intended primarily for the treatment of obesity, morbid obesity or similar condition involving a member's weight.
 20. Hypnosis or Hypnotherapy.
 21. Treatment for smoking or nicotine addiction.
 22. Biofeedback or other services including acupuncture, massage therapy, music therapy, aqua therapy, aromatherapy or any alternative therapy (ies).
 23. Spinal manipulation for chronic neuromusculoskeletal conditions and any non-neuromusculoskeletal conditions.
 24. Care for health conditions that are required or directed by state or local authorities to be treated in a public facility.
 25. Care or supplies furnished by a facility operated for or by the U.S. Government or its agency or by a physician employed by that facility unless for emergency care when the member must pay for those services, for non-service connected disabilities in a Veterans Administration Hospital or incurred by a U.S., military retiree (covered by this Agreement) and his or her covered dependents, while confined in a military medical facility.
 26. Care and services to the extent furnished or payable under a plan or program operated by the federal or state government or one of its agencies or while the member is active in the military. This exclusion will not apply to benefits received under the Medicaid program of the State of Texas.
 27. Care and supplies for which no charge is made or for which the member would not have to pay if the member did not have this coverage.
 28. Health services provided prior to the effective date or after the termination date of the member's coverage under the Group Service Agreement.
 29. Non-covered services and supplies, including but not limited to
 - Ambulatory blood pressure monitor (unless member is a diabetic)
 - Refractive eye surgery,
 - Immunotherapy for food allergy
 - Genetic testing.
- Items of equipment not primarily used for a medical purpose such as
- exercise cycles or exercise equipment
 - air conditioners
 - humidifiers
 - personal comfort items

Benefit Administration: UniCare Texas HMO

- motorized transportation equipment or motorized wheelchairs, escalators or elevators
- saunas or swimming pools
- items not authorized by a Participating Physician or Participating Provider.

Equipment and appliances considered dispensable or convenient for use in the home, such as

- dressings or disposable over-the-counter cervical collars
- corrective shoes and shoe inserts unless member is a diabetic
- air filtering units
- aphakic lens
- bandage lens
- blood pressure cuffs/stethoscopes
- corset/girdles
- intercom systems
- battery-operated nebulizers
- overbed tables
- oxygen cylinder racks
- pacemaker monitors
- restraints/safety equipment
- seat lift chairs and similar apparatus
- shower bench
- stools/chairs
- support garments (such as Jobst stockings)
- toilet rails and seats
- urinals/bed pans
- vacuum device for impotence
- vacuum systems
- vibration/massage units or chairs
- whirlpools

30. Replacement or repair of Durable Medical Equipment damaged or disabled as a result of circumstances beyond the normal use and/or wear and tear of the equipment.
31. Any service rendered by a close relative or someone having the same legal residence as the patient. (“Close relative” means a member’s spouse, the brother, sister, parent or child of a member or member’s spouse.)
32. Thermograms, temperature gradient studies.
33. Exercise for the eyes (orthoptics).
34. Non-emergency transportation.
35. Reduction mammoplasty.
36. Care provided by a Christian Science Practitioner.

Benefit Administration: UniCare Texas HMO

37. All over-the-counter formulas or nutritional supplements to be used for enteral feeding, except for the treatment of PKU or other heritable diseases when this Group Service Agreement includes a prescription drug rider.
38. Any services or costs related to a member acting as an organ donor including the determination of the members suitability to provide an organ donation.
39. Drugs prescribed, directed or authorized by a Primary Care Physician to be consumed or administered in a physician's office or while confined in a participating hospital or approved health care facility on an inpatient basis.
40. Health Services furnished due to war or an act of war (declared or undeclared).

Physician Rights and Responsibilities: UniCare Texas HMO

UniCare requires each 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 with chronic, disabling, life-threatening, complex diagnoses and/or special needs may designate an SCP as his/her primary care physician. In these situations the specialist accepts responsibility for all facets of the member's care.

Physicians with the following specialties may request PCP designation:

- Cardiology
- Endocrinology
- Gastroenterology
- Hematology/Oncology
- Infectious Disease
- Nephrology
- Neurology
- Pulmonary Medicine
- Rheumatology

Call the Case Management nursing staff at (713) 479-4275 or (800) 510-4569 or the Medical Director at (713) 479-4411 to discuss the Specialist as PCP model.

The relationship between UniCare and 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. Providing regular checkups
2. Referring 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

PCPs must also document and enforce policies describing the duties of employed physician assistants, advance practice nurses and any individuals other than physicians in accordance with statutory requirements for licensure, delegation, collaboration and supervision.

Note:

- Change of PCP is effective the 1st day of the month after the member makes the request. PCP changes are not made retroactively.
- OB/GYNs are not considered PCPs.

Physician Rights and Responsibilities: UniCare Texas HMO

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 the member’s noncompliance or disruptive conduct, 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 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. Communicating with the PCP regarding services rendered, results, reports and recommendations.
2. Advising UniCare of catastrophic or special need cases.
3. Providing appropriate health education for members.
4. Complying and cooperating with medical management guidelines.

Network Participation/Status Changes

Network Utilization

Network physicians must use the services of 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.

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 90 days prior to date of change.
- 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.

Physician Rights and Responsibilities: UniCare Texas HMO

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.

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

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 contracted physicians. If the covering physician is not contracted with UniCare, the network physician must obtain agreement from a non-contracted physician to abide by the terms of the Physician Agreement including fee schedule, protocols and prior authorization requirements.

Medical Emergencies

A medical emergency is defined as

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 Rights and Responsibilities: UniCare Texas HMO

Advance Directives

UniCare is required by law to inform members of their right to make health care decisions and to execute advance directives. An advance directive is a formal document written by the member/patient in advance of an incapacitating illness or injury. As long as the member/patient can speak for him/herself, contracted physicians must honor their wishes.

If the member/patient becomes so sick that he/she cannot speak for him/herself, this directive will guide the physician and make the member's wishes known to family and friends.

There are several types of advance directives to choose from. Most states recognize

- Durable Power of Attorney for Health Care
- Living Will
- Natural Death Act Declarations

Members may obtain forms from a network physician or UniCare Customer Service.

Members/patients are not required to initiate an advance directive and no member should be denied care if he/she does not have an advance directive. Members may file a complaint with the appropriate state agency if they believe their physician has not complied with their advance directives.

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
Attn: Network Services
Two Greenway Plaza #300
Houston TX 77046

A UniCare representative will make every attempt to resolve the issue to the physician's satisfaction within 30 business days.

For information regarding Claim Appeals, see Claims Submission.

For information regarding Member Appeals, see Member Rights and Responsibilities.

Member Rights and Responsibilities: UniCare Texas HMO

The following rights and responsibilities are communicated to each UniCare HMO member.

As a member of the UniCareHMO you have the right to

- Information about your HMO plan, services provided by your HMO plan, physicians in your network and the right to receive the Member Rights and Responsibilities statement.
- Confidentiality of your medical record and the access to information contained in your medical record unless release of the information as required or permitted by law, or by UniCare, or if you consent to the release.
- Privacy during office visits and to be treated with respect and dignity.
- Choose a Primary Care Physician (PCP) from those contracted with UniCare.
- Participate in decisions involving your medical care. You should be provided enough information to come to an informed decision regarding the treatment or procedure. This information should include the specific diagnosis, plan of care, risks(s) involved and expected results. You have the right to a candid discussion of appropriate or medically necessary treatment options, regardless of cost or benefit coverage.
- Voice complaints and appeals about UniCare or the care provided to you. You further have the right to receive the assistance from UniCare's Customer Service department regarding a complaint about UniCare and/or the care you have received.
- Suggest how we can improve our service to you and other members.

As a member of UniCare you have a responsibility to

- Contact your PCP to arrange for health care services other than mental health services or obstetrical and/or gynecological services.
- Contact the UniCare Customer Service department when you need information about your coverage.
- Present your UniCare identification card to a physician before receiving services.
- Comply with your health care physician's treatment plan concerning instructions, medications, diet and exercise.
- Comply with UniCare's rules for members.
- Notify your PCP if possible before obtaining treatment in an emergency room except in life threatening emergency situations.
- Arrive on time for appointments, or cancel when appropriate, with at least 24-hour notice if possible.
- Communicate openly and provide the necessary medical history required by your health care provider so that he/she may care for you.

Member Rights and Responsibilities: UniCare Texas HMO

Member Complaint and Appeals Process

Members are encouraged to discuss concerns about UniCare with Customer Service. If the concern involves a physician, UniCare will contact the physician or provider for information and any medical records related to the concern.

A member, or someone acting on the member's behalf, may register a complaint or appeal by calling the Customer Service number on the member's ID card or (888) 955-4200 or by writing to

Grievance and Appeals Department
UniCare
233 S Wacker Drive, Suite 3900
Chicago IL 60606

A UniCare representative will make every attempt to resolve the issue to the member's satisfaction within 30 business days. UniCare will send the member a detailed description of the complaint process. Upon resolution, a letter will be sent to the member.

If the member is not satisfied with the resolution, the member may appeal the decision. UniCare will send written information to the member explaining the appeal process, including the right to present information to the Complaint Appeal Panel. Results of the Panel's recommendation, which is not binding on UniCare, will be communicated to the member and physician in writing.

A member may contact the Texas Department of Insurance if he/she is not satisfied with the outcome of the appeal. Providers will post in an open area a notice to members outlining the process for resolving complaints with UniCare. The notice must include the Texas Department of Insurance's toll-free telephone number for filing complaints.

Credentialing and Recredentialing: UniCare Texas HMO

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

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

Confidentiality

- Information obtained during the credentialing or recredentialing process is confidential.
- Discussions of the Credentialing Committee are protected by federal peer review laws.
- All Credentialing Committee meeting minutes and provider files are stored in a secure area accessible only to authorized personnel and are not reproduced or distributed except for credentialing/recredentialing 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 Credentials Committee. This committee is comprised of participating network physicians and meets at least quarterly.
3. Formal notification to provider of the credentialing decision.

Credentialing and Recredentialing: UniCare Texas HMO

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 raised 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.

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.

Credentialing Made Easy

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. You can update your information anytime and changes are made available to the plans and organizations you 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/cred to enter credentialing data at your convenience.

Credentialing Status

Call 1-800-848-7347

Quality Management: UniCare Texas HMO

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:

Quality Management Department
UniCare
Two Greenway Plaza, #500
Houston, TX 77046

Medical Record Standards for UniCare Health Plans of Texas Inc.

Participating providers are required to meet UniCare Health Plans of Texas (UHPT) requirements for medical record documentation standards, availability, maintenance and confidentiality. Physicians agree to make medical records available for the purposes of quality reviews in accordance with contractual obligations.

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

- Information must be legible to someone other than the author.
- Member name must be listed on each page (front and back).
- All entries must be signed and dated.
- Medications, allergies and adverse reactions, or absence of allergies must be noted prominently.
- Significant illnesses and chronic medical conditions are noted on the problem list.
- Consultation, post-hospital discharge, ER visit and follow-up plans are noted.
- Abnormal test results show evidence of review by the physician and a follow-up plan for abnormal results is documented.

Organization Standards

Practice offices maintain an individual medical record for each patient. Each medical record 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

Quality Management: UniCare Texas HMO

- 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 Access Standards

UniCare HMO has established the following standards for scheduling appointments with primary care physicians (PCPs):

- Complete physical examination within 6 weeks
- Initial prenatal visit within 30 calendar days
- Non-urgent medical examination within 14 days
- Urgent care within 24 hours
- Emergent care available the same day
- After hours access to an on-call physician 24 hours/day, 7 days/week

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 HMO provides Health Improvement Programs for diabetes, asthma and congestive heart failure (CHF). These programs are designed to 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. When necessary, UniCare HMO assists individuals who are managing their chronic conditions.

UniCare's Clinical Quality Improvement Committee (CQIC), which includes network practitioners, has approved the following guidelines.

- Diabetes: ADA Clinical Practice Recommendations 2003, as published in the January 2003 Supplement 1 to *Diabetes Care*. These guidelines can be found on the Internet at www.diabetes.org.
- Asthma: NAEPP Expert Panel Report 2: Guidelines for the Diagnosis and Management of Asthma, 1997, and the Update on Selected Topics, 2002. These guidelines can be found on the Internet at www.nhlbi.nih.gov/guidelines/asthma.
- CHF: ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult, as published in *Circulation* 2001;104:2996-3007. These guidelines can be found on the Internet at www.acc.org and at www.americanheart.org.

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 or CHF, please call the Quality Management Department at (312) 234-7315.

Quality Management: UniCare Texas HMO

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 ensure that 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 Healthplan Employer Data and Information Set (HEDIS) is a set of standardized performance measures designed by the National Committee for Quality Assurance (NCQA) to ensure 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

Quality Management: UniCare Texas HMO

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 Peer Review Subcommittee reviews cases determined to have a potential quality of care issue of major clinical significance. 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. In addition, the Peer Review Subcommittee may deem specific corrective action plans necessary.

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 contracted provider may initiate a clinical complaint.

HIPAA: UniCare Texas HMO

The Health Insurance Portability and Accountability Act (HIPAA) was passed to reduce healthcare administrative costs, protect individuals' privacy and insurability, and enhance measures to limit fraud and abuse. The Act contains several components mandating continuing health 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 are compliant with all current requirements and expect to be compliant with future requirements as they are due.

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