UnitedHealthcare Community Plan

Reimbursement Policy Update Bulletin: November 2024

New			
Policy Title	**State(s)**	**Policy summary**	**Effective Date**
Readmission Policy, Facility	District of Columbia	• Effective with claims dates of services on or after December 01, 2024, the Readmission Policy, Facility will be applied to the District of Columbia. • Consistent with the Centers for Medicare and Medicaid Services (CMS), the UnitedHealthcare Community Plan Readmission Policy, Facility outlines the review process of all Readmissions an acute care hospital within 30 days of discharge.	December 01, 2024
Sexually Transmitted Infection Testing Policy, Professional and Facility	New York	• Effective with claims dates of service 12/01/2024 and after, the Sexually Transmitted Infection Testing Policy, Professional and Facility (STI) will be applied to New York. • UnitedHealthcare Community Plan STI policy allows reimbursement for the comprehensive Test code CPT 87801 when two or more single test codes (CPT 87491, 87591 and/or 87661) are reported for the same member by the same provider and same date of service. • Payment will be made based on a single unit of 87801 regardless of the units billed for a single code.	December 01, 2024

Molecular Pathology Policy, Professional and Facility	Colorado District of Columbia Florida Hawaii Kentucky Maryland Massachusetts Michigan Minnesota Missouri New Jersey New Mexico New York North Carolina Pennsylvania Rhode Island Tennessee Texas Virginia Washington Wisconsin	• Effective with dates of service on or after 02/01/2025 UnitedHealthcare Community Plan will revise the Molecular Pathology Policy, Professional. • The updated reimbursement policy requirements will apply to both professional and facility claims, and the policy name will be updated to Molecular Pathology Policy, Professional and Facility. • The policy will require the submission of a DEX Z-code® which would be obtained from the Palmetto DEX Registry for claims to be considered for reimbursement. • The registry can be found on www.dexzcodes.com. • Claims for molecular pathology services will be denied if the DEX Z- code® information is missing, invalid, or does not match the service represented by the CPT code reported on the claim. • Claims denied for missing or invalid information may be resubmitted with the required information. • The Palmetto DEX Z- code® should be reported in Loop 2400 or SV-101-7 for professional electronic claims and in box 19 for paper claims. Facility claims should be reported in Loop 2400 or SV-202-7.	February 01, 2025

Hospital Inclusive Charges Policy, Facility – Reminder *Additional Information*	Ohio	• UnitedHealthcare will publish a new Hospital Inclusive Charges Policy, Facility that is in accordance with the Centers for Medicare and Medicaid Services' Provider Reimbursement Manual. This policy aims to provide guidelines on which items or services are not eligible for separate reimbursement during both inpatient and outpatient hospital visits. • Certain categories of items and services are included within the overall room and board or facility fee charge for an inpatient or outpatient visit, or otherwise bundled within services provided as part of the visit, and therefore are not considered separately reimbursable by UnitedHealthcare. • Why did UnitedHealthcare publish this policy? UnitedHealthcare introduced the Hospital Inclusive Charges Policy to provide greater transparency into our process regarding items associated with certain inpatient and outpatient stays that aren't considered separately reimbursable. These items are already included within the room and board reimbursement or the reimbursement for an underlying procedure, as applicable. • What should facilities expect to see differently? Facilities already receive documentation requests to ensure reimbursements comply with policy requirements as part of our standard process. This will provide greater transparency into that process, which is used today in reviews and audits of claims paid on a percent of charge basis such as itemized bill reviews and hospital bill audits.	December 01, 2024

<table>
<tr>
<td>Radiation Therapy – Dosimetry, Simulation/Devices and Management Policy, Professional and Facility</td>
<td>Colorado
Hawaii
Maryland
Missouri
New York
North Carolina
Pennsylvania
Washington
Wisconsin</td>
<td>

Effective for dates of service on or after February 1, 2025, UnitedHealthcare will implement the new Radiation Therapy – Dosimetry, Simulation/Devices and Management Policy, Professional and Facility.
Radiation therapy dosimetry, simulation, and management services, identified with select CPT® codes, will have unit limitations during a 90-day episode of care, as noted below. Units billed in excess of the reimbursable units will not be considered for reimbursement.

<table>
<tr><th>Procedure Code</th><th>Reimbursable Units</th><th>Descriptions</th><th>Treatment Description</th></tr>
<tr><td>77280</td><td>4</td><td>Therapeutic radiology simulation-aided field setting; simple</td><td>Simulation</td></tr>
<tr><td>77285</td><td>2</td><td>Therapeutic radiology simulation-aided field setting; intermediate</td><td>Simulation</td></tr>
<tr><td>77290</td><td>3</td><td>Therapeutic radiology simulation-aided field setting; complex</td><td>Simulation</td></tr>
<tr><td>77295</td><td>2</td><td>3-dimensional radiotherapy plan, including dose-volume histograms</td><td>3-D Radiotherapy</td></tr>
<tr><td>77300</td><td>10</td><td>Basic radiation dosimetry calculation</td><td>Basic Dosimetry</td></tr>
<tr><td>77301</td><td>5</td><td>Intensity modulated radiotherapy plan, including dose-volume histograms</td><td>IMRT Dose Planning</td></tr>
<tr><td>77332</td><td>10</td><td>Treatment devices, design and construction; simple</td><td>Treatment Devices</td></tr>
<tr><td>77333</td><td>10</td><td>Treatment devices, design and construction; intermediate</td><td>Treatment Devices</td></tr>
<tr><td>77334</td><td>10</td><td>Treatment devices, design and construction; complex</td><td>Treatment Devices</td></tr>
<tr><td>77338</td><td>5</td><td>Multi-leaf collimator (MLC) design and construction per IMRT plan</td><td>MLT Device for IMRT</td></tr>
<tr><td>77427</td><td>9</td><td>Radiation treatment management, 5 treatments</td><td>Radiation Therapy Treatment Mgmt</td></tr>
<tr><td>77431</td><td>1</td><td>Radiation therapy management with complete course of therapy</td><td>Radiation Therapy Treatment Mgmt</td></tr>
<tr><td>77435</td><td>1</td><td>Stereotactic body radiation therapy, treatment management</td><td>Radiation Therapy Treatment Mgmt</td></tr>
</table>

These limits apply only to codes for the dosimetry, simulation, and management aspect of radiation therapy treatment planning and not to radiation therapy treatment itself.
A 90-day episode of care begins when one of the therapeutic radiology treatment planning CPT® codes (77261, 77262, and 77263) are billed. A new episode of care begins again if a radiation treatment planning code is submitted before the previous 90-day episode of care ends.

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<td>February 01, 2025</td>
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Revised			
Policy Title	**State(s)**	**Summary of Changes**	**Effective Date**
Preventive Medicine and Screening Policy, Professional	Texas	• The UnitedHealthcare Community Plan Preventative Medicine and Screening Policy will be enhanced effective with dates of service 08/01/2024 to apply a 50% reduction to an Evaluation and Management (E/M) service reported with modifier 25 when reported with a Preventative Medicine E/M service on the same day for the same patient by the same provider. • The adjustment considers expenses that overlap with Preventative Medicine practice expenses, which may include for example, supplies, equipment, and administrative overhead.	February 01, 2025
Diagnosis Code Requirement Policy, Professional and Facility	Texas	• Effective with dates of service May 1, 2024, UnitedHealthcare Community Plan will introduce a comprehensive Diagnosis Code Requirement Policy for both Professional and Facility services. This new policy will integrate the existing ICD-10-CM guidelines covered by the Outpatient Hospital Inappropriate Primary Diagnosis Codes Policy, Facility, and the Inappropriate Primary Diagnosis Codes Policy, Professional. o Additionally, effective January 1, 2025, the policy will address the Excludes 1 coding within the ICD-10 CM framework. Excludes 1 guidelines denote mutually exclusive codes, representing two conditions that cannot be reported together – such as a congenital form verses an acquired form of the same condition. All providers should align to coding with the Excludes 1 guidelines when submitting claims; however, at this time the application of these guidelines is specifically for Inpatient Claims. • Providers are expected to accurately submit diagnosis codes in alignment with ICD-10-CM requirements.	January 01, 2025

Preventive Medicine and Screening Policy, Professional	Minnesota	• The UnitedHealthcare Community Plan Preventative Medicine and Screening Policy will be enhanced effective with dates of service 08/01/2024 to apply a 50% reduction to an Evaluation and Management (E/M) service reported with modifier 25 when reported with a Preventative Medicine E/M service on the same day for the same patient by the same provider. • The adjustment considers expenses that overlap with Preventative Medicine practice expenses, which may include for example, supplies, equipment, and administrative overhead.	January 01, 2025
CCI Editing Policy, Professional and Facility	Colorado Florida Hawaii Maryland Massachusetts Michigan Minnesota Missouri New Mexico New York North Carolina Pennsylvania Rhode Island Virginia Washington Wisconsin	• Effective for dates of service on or after Feb 1, 2025, UnitedHealthcare Community Plan will align with The Centers for Medicare and Medicaid (CMS) by enhancing the existing CCI Editing, Professional and Facility policy to support claim line denials when there are two shoulder arthroscopic procedures performed on the same shoulder. • In accordance with CMS National Correct Coding Initiative (NCCI) CPT codes 29805-29828 Procedure to Procedure (PTP) edit code pairs consisting of two codes describing two shoulder arthroscopy procedures performed on the same shoulder will not be considered for separate reimbursement regardless if the code is appended with an NCCI PTP associated modifier. This includes the use of modifier 59. • PTP edit code pairs will be considered for separate reimbursement when performed on opposite shoulders and when appended with an appropriate NCCI PTP associated modifier. • There are three exceptions which are described in Chapter IV, Section E (Arthroscopy), Subsection 7 of the NCCI manual. The following CPT codes will be considered for separate reimbursement when submitted in addition to code 29823 if extensive debridement is completed in a different area of the same shoulder. o 29824 (Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure) o 29827 (Arthroscopy, shoulder, surgical; with rotator cuff repair) o 29828 (Arthroscopy, shoulder, surgical, biceps, tenodesis.	February 01, 2025

Code Update			
Policy Title	**State(s)**	**Summary of Changes**	**Effective Date**

Reimbursement Policy Code Updates – Multiple Policies	Multiple	In response to Provider feedback and in an effort to provide more transparency, UnitedHealthcare is providing additional information regarding code updates that impact reimbursement policies. These updates are not changing the intent or the coding requirements of the policy, but reflect changes made to industry standard code sets.
		• Information regarding these code updates can be found in the history section which is located at the end of the posted policy.
		• Code sections/lists/tables within a policy may not be comprehensive but may be provided as examples. Please review the full policy to understand applicability.
		• Code updates could include, for example, CPT, HCPCS, ICD-10, Modifiers, Revenue Codes, or other industry standard code sets.
		• UnitedHealthcare routinely updates its reimbursement policies in response to code updates made by, for example, Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), and the World Health Organization (WHO). This information is provided as a courtesy and may not include all code updates.
		• Check published policy to determine impact at the state level.
		• The following UnitedHealthcare policies have recently been updated to include code changes:
		  • Add-On Codes, Facility
		  • Add-On Codes, Professional
		  • Age to Diagnosis Code and Procedure Code Policy, Professional
		  • Ambulance Services, Professional
		  • Anatomical Modifier Requirement Policy, Professional
		  • Assistant-at-Surgery Services, Professional
		  • Bilateral Procedures, Professional
		  • Consultation Services, Professional
		  • Contrast & Radiopharmaceutical Materials, Professional
			November 01, 2024

Code Update			
Policy Title	**State(s)**	**Summary of Changes**	**Effective Date**
		• Co-Surgeon/Team Surgeon, Professional • Device, Implant, and Skin Substitute Policy, Facility • Diagnosis Code Requirement Policy, Professional and Facility • Discarded Drugs and Biologicals, Professional and Facility • DME, Orthotics and Prosthetics, Professional • Drug Testing Reimbursement Policy, Professional • From - To Date, Professional • Gender to Procedure and Diagnosis, Professional • Injection & Infusion Services, Professional • Maximum Frequency per Day CPT, Professional • Maximum Frequency per Day HCPCS, Professional • Medically Unlikely Edits (MUE), Professional and Facility • Modifier Reference, Professional • Mohs Micrographic Surgery Policy, Professional • Non-Covered and Covered Codes Policy, Facility • Non-Covered and Covered Codes Policy, Professional • Obstetrical Services, Professional • Outpatient Hospital Observation Policy, Facility • Preventive Medicine and Screening, Professional • Procedure and Place of Service, Professional • Procedure to Modifier, Professional • Readmission, Facility • Revenue Codes Requiring Procedure Codes, Facility • Supply Policy, Professional • Telehealth/Virtual Health Policy, Professional and Facility • Time Span Codes Policy, Professional • Unlisted Services Policy, Professional • Vaccines For Children Policy, Professional	

Published reimbursement policies are intended to ensure reimbursement based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies may use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

Note: The absence of a policy does not automatically indicate or imply coverage. As always, coverage for a health service must be determined in accordance with the member's benefit plan and any applicable federal or state regulatory requirements.

The complete library of UnitedHealthcare Community Plan Reimbursement Policies is available at **UHCprovider.com** > Policies and Protocols > Community Plan Policies > Reimbursement Policies for Community Plan.