



## **Implementation of a New Reimbursement Policy and Changes to Existing Reimbursement Policies**

### **Reimbursement Policy Changes — Effective August 20, 2016**

Effective for claims processed on or after August 20, 2016, UnitedHealthcare Community Plan will implement revisions made to the following reimbursement policies:

- CCI Editing Policy
- Durable Medical Equipment, Orthotics, and Prosthetics Multiple Frequency Policy
- Incontinence Supplies Policy
- Laboratory Services Policy
- T Status Codes Policy

### **New Reimbursement Policy— Effective September 1, 2016**

Effective for claims with dates of service on or after September 1, 2016, UnitedHealthcare Community Plan will implement the following reimbursement policy:

- Consultation Services Policy

### **CCI Editing Policy:**

#### **Correct Reporting of Modifiers on Ipsilateral Organs or Structures**

Modifiers which are recognized by UnitedHealthcare Community Plan in the CCI Editing policy follow the CMS National Correct Coding Initiative (NCCI) designated modifiers for Procedure-to-Procedure (PTP) edits: 24, 25, 57, 58, 59, 78, 79, 91, E1, E2, E3, E4, LC, LD, LM, LT, RC, RI, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, XE, XP, XS and XU.

Each NCCI edit has a modifier indicator assigned to it. A modifier indicator of "0" indicates that a modifier cannot be used to bypass the edit, and a modifier indicator of "1" indicates that an NCCI designated modifier can be used to allow both of the reported services or procedures.

According to the [NCCI Coding Policy Manual](#), most edits involving paired organs or structures have NCCI PTP modifier indicators of "1" because the two codes of the code pair edit may be reported if performed on the contralateral organs or structures. However, if performed on the ipsilateral organ or structure, most of these code pairs should not be reported with the following NCCI-associated modifiers unless there is a specific coding rationale to bypass the edit: E1, E2, E3, E4, LC, LD, LM, LT, RC, RI, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, FA, F1, F2, F3, F4, F5, F6, F7, F8, and F9. The existence of the NCCI PTP edit indicates that the two codes generally cannot be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic locations. In order to comply with

CMS NCCI correct coding standards, the same anatomical modifier on both codes will no longer bypass the CCI bundling edits.

**Durable Medical Equipment, Orthotics, and Prosthetics Multiple Frequency Policy (Medicaid Only):**

The UnitedHealthcare Community Plan Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency Policy for will be revised to consider reimbursement for the monthly rental of a second ventilator reported with a rental modifier plus modifier KX (Requirement specified in the medical policy have been met) in accordance with the UHG Coverage Determination Guidelines. Monthly rentals of back-up ventilators reported with modifier TW (back-up equipment) will no longer be considered for reimbursement.

**Note:** This revision will not apply to UnitedHealthcare Community Plan Medicare products.

**Incontinence Supplies Policy:**

UnitedHealthcare Community Plan currently denies incontinence supplies when one or more diagnosis code(s) listed in the Incontinence Supply Policy are the ONLY diagnosis code(s) on the claim. Claims for incontinence supplies must contain a diagnosis reflecting the medical condition causing incontinence.

For claims processed on or after August 20, 2016 with a date of service on or after 10/1/2015, there must be more than one ICD-10 diagnosis code billed for incontinence supplies. An ICD-10 diagnosis code from the approved ICD-10 diagnosis codes list in the policy *and* an ICD-10 diagnosis code reflecting the condition causing incontinence, must both be present on the claim. If only incontinence diagnosis codes are on the claim, all incontinence supplies will be denied.

Claims with dates of service prior to 10/1/2015 will not be affected by this change and will continue to deny if one or more of the code(s) from the approved ICD-9 diagnosis list are the ONLY diagnosis code(s) on the claim.

In addition, UnitedHealthcare Community Plan will be updating the ICD-10 Diagnosis Codes List with additional codes reflecting the type of incontinence. For the current list of diagnosis codes, please refer to the Incontinence Supply Policy posted under the Reimbursement Policy section on <http://www.uhccommunityplan.com/>.

**Laboratory Services and T Status Codes Policies:**

UnitedHealthcare Community Plan will revise two reimbursement policies to better align with the Centers for Medicare and Medicaid Services (CMS) that address separate payment of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes assigned a status indicator of T on the CMS National Physician Fee Schedule (NPFs). Consistent with CMS, UnitedHealthcare Community Plan will only deny separate reimbursement of a CPT or HCPCS code assigned a status of T when also reported with a CPT or HCPCS code assigned a status of A, R or T by the same physician or other health care professional for the same patient and the same date of service. When two codes assigned a T status are reported without any other payable service, the T status code with the highest Relative Value Unit will be reimbursed.

- The Laboratory Services Policy will be revised to consider two T Status Codes which describe the collection of a Specimen from a completely implantable venous access device and from an established catheter (CPT codes 36591 and 36592) to be payable only if there are no other services payable that are assigned a status of A, R or T on the same day by the same provider. When CPT code 36591 is submitted with CPT code 36592, CPT code 36592 is the only venipuncture code considered eligible for reimbursement.
- For UnitedHealthcare Community Plan Medicare only, the T Status Codes Policy will be revised to address all codes with the exception of CPT 36591 and 36592 which will implement as a revision to the Laboratory Services Policy.

**Note:** The revision for the T Status Codes Policy will not apply to UnitedHealthcare Community Plan Medicaid products.

For a comprehensive list of services assigned a status of A, R, or T please go to:  
CMS NPFS:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU16B.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending>

### **Consultation Services Policy:**

#### **UnitedHealthcare Community Plan Medicaid:**

Effective for services provided on or after September 1, 2016 a new Consultation Services Policy will be implemented to align with the American Medical Association (AMA) CPT® guidelines for consultation codes 99241 – 99245, 99251 - 99255, G0406 – G0408 and G0425 – G0427. The guidelines specify that consultation codes should be reported when provided at the request of another physician or another appropriate source. A “consultation” initiated by a patient and/or family and not requested by physician or other appropriate source should not be reported using the consultation codes, but may be reported using the office visit, subsequent hospital care, home service or domiciliary/rest home care codes as appropriate.

The new policy will also include a limitation for inpatient consultations. AMA guidelines state that only one inpatient consultation (99251-99255) should be reported by a consultant per admission. Evaluation and Management (EM) services after the initial consultation during a single admission should be reported using non-consultation EM codes.

Effective for September 1, 2016 dates of service and after, UnitedHealthcare will allow reimbursement for consultation codes only when the referring entity’s name and/or National Provider Identifier (NPI) are reported on the claim. Upon implementation, the new policy name will be the Consultation Services Policy.

#### **UnitedHealthcare Community Plan Medicare:**

Effective January 1, 2010 CMS ceased reimbursing Evaluation and Management (E/M) codes describing consultation services (CPT 99241-99245 and 99251-99255) in all places of service. The codes were assigned a status indicator of "I" beginning with the January 2010 National Physician Fee Schedule (NPFS). Therefore, effective for September 1, 2016 dates of service and after, UnitedHealthcare Community Plan will not reimburse consultation codes 99241 – 99245 or 99251-99255 for Medicare members. HCPCS consultation codes G0406-G0408 or

G0425-G0427 will be considered for reimbursement for Medicare members if the requesting or referring provider or other appropriate source is identified on the claim.

Unless otherwise noted, this announcement pertains to reimbursement policies for services reported using the 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent or its successor form.

#### **Note Regarding Reimbursement Policies**

***As with all UnitedHealthcare Community Plan policies, other factors affecting reimbursement may supplement, modify or in some cases supersede this policy. These factors include but are not limited to federal and/or state regulatory requirements, physician or other provider contracts, and/or the member's benefit coverage documents.***

Unless otherwise noted as follows, these reimbursement policies apply to services reported using the CMS-1500 or its electronic equivalent, or its successor form.

UnitedHealthcare Community Plan reimbursement policies do not address all issues related to reimbursement for services rendered to our members, such as the member's benefit plan documents; our medical policies; and the UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide. Meeting the terms of a particular reimbursement policy is not a guarantee of payment. Likewise, retirement of a reimbursement policy affects only those system edits associated with the specific policy being retired. Retirement of a reimbursement policy is not a guarantee of payment. Other applicable reimbursement and medical policies and claims edits will continue to apply.

Once implemented, the policies may be viewed at [UHCCCommunityPlan.com](http://UHCCCommunityPlan.com) > For Health Care Professionals (click on the appropriate state) > Reimbursement Policies.

In the event of an inconsistency or conflict between the information in this Provider Notification and the posted policy, the provisions of the posted reimbursement policy prevail. If you have any questions, please contact your Health Plan Representative or call the number on your Provider Remittance Advice/Explanation of Benefits.