Updates to Reimbursement Policies

Reimbursement Policy Changes — Effective May 21, 2016

Effective for claims processed on or after May 21, 2016, UnitedHealthcare Community Plan will implement revisions made to the following reimbursement policy:

- Supply Policy

Reimbursement Policy Changes — Effective June 1, 2016

Effective for claims with dates of service on or after June 1, 2016, UnitedHealthcare Community Plan will implement revisions made to the following reimbursement policies:

- Inappropriate Primary Diagnosis Codes Policy
- Obstetrical Services Policy

New Reimbursement Policy— Effective June 1, 2016

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

- Diabetic Testing Strips and Lancets Policy

Supply Policy:
UnitedHealthcare Community Plan currently denies certain Healthcare Common Procedure Coding System (HCPCS) supply codes which are considered incorporated into the Practice Expense Relative Value Unit (PE RVU) for Evaluation and Management (E/M) services and/or procedures reported on the same day in a physician or other health care professional’s office (places of service 03, 11, 49, 71 and 72). According to the Centers for Medicare and Medicaid Services (CMS), services paid at nonfacility rates are inclusive of costs related to providing that service in an office/clinic setting, patient home or other non-facility setting.

UnitedHealthcare Community Plan will further align the Supply policy with CMS by the addition of the following nonfacility places of service where supplies will no longer be separately reimbursed when reported with an E/M service and/or procedure with the same date of service by the same provider: 01, 04, 09, 12, 13, 14, 15, 16, 17, 20, 33, 50, 54, 55, 57, 60, 62, 65, 81 and 99. For a complete list of CMS place of service codes with descriptions, please see the CMS POS Code Set.

Durable Medical Equipment and Home Health providers will be excluded from this enhancement due to certain contracting and coverage guidelines.
In addition, UnitedHealthcare Community Plan will be updating the Non Reimbursable Supply Codes List with additional codes that are not separately reimbursable. The list is based on the CMS NPFS Relative Value File and consists of codes that based on their descriptions, CMS considers part of the practice expense and not separately reimbursable.

**Inappropriate Primary Diagnosis Codes Policy:**
UnitedHealthcare Community Plan currently denies claims where an inappropriate diagnosis is pointed to or linked as primary in box 24E on a CMS-1500 claim form or its electronic equivalent. When a code on the Inappropriate Primary Diagnosis List is pointed to or linked as the primary diagnosis on the claim form, the associated claim line(s) will be denied.

Upon review of the ICD-10 guidelines published by CMS effective October 1, 2015, clearer specificity was provided as it relates to the use of “code first” guidelines and correct sequencing of diagnosis codes. As a result, UnitedHealthcare Community Plan will be adding several diagnosis codes to the inappropriate primary diagnosis codes list. The ICD-10-CM Official Coding Guidelines can be found at the following link: [http://www.cdc.gov/nchs/data/icd/10cmguidelines_2016_Final.pdf](http://www.cdc.gov/nchs/data/icd/10cmguidelines_2016_Final.pdf).

For the current list of ICD-10 diagnosis codes that cannot be reported as a primary diagnosis, please refer to the Inappropriate Primary Diagnosis Codes Policy posted under the Reimbursement Policy section on [http://www.uhccommunityplan.com/](http://www.uhccommunityplan.com/).

**Obstetrical Services Policy:**
To align more comprehensively with the American Medical Association (AMA) Current Procedural Terminology (CPT) guidelines and with the American Congress of Obstetricians and Gynecologists (ACOG) recommendations, UnitedHealthcare Community Plan will no longer pay separately for routine urinalysis, CPT codes 81000 and 81002, when performed as part of the global obstetric package or antepartum care.

Individual State exceptions will be noted in the State Exceptions Section of the Obstetrical Services Policy.

**Diabetic Testing Strips and Lancets Policy:**
**Note:** This policy will not apply to UnitedHealthcare Community Plan Medicaid products. It will apply only to UnitedHealthcare Community Plan Medicare products.

To align with the Centers for Medicare and Medicaid Services (CMS), UnitedHealthcare Community Plan will apply CMS’s unit limits for diabetic testing strips and lancets.

**Quantity of test strips (A4253) and lancets (A4259)**
The quantity of test strips (A4253) and lancets (A4259) covered depends on the usual medical needs of the beneficiary and whether or not the beneficiary is being treated with insulin, regardless of their diagnostic classification as having Type 1 or Type 2 diabetes mellitus.

For a beneficiary who is not currently being treated with insulin injections, up to 100 test strips and up to 100 lancets every 3 months are covered if the basic coverage criteria are met. Modifier KS must be appended.
For a beneficiary who is currently being treated with insulin injections, up to 300 test strips and up to 300 lancets every 3 months are covered if basic coverage criteria are met. Modifier KX must be appended.

The following modifiers are used to indicate if the beneficiary is insulin dependent or non-insulin dependent, and are required to be appended with HCPC codes A4253 and A4259:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>KS</td>
<td>Glucose monitor supply for diabetic beneficiary not treated with insulin</td>
</tr>
<tr>
<td>KX</td>
<td>Requirements specified in the medical policy have been met</td>
</tr>
</tbody>
</table>

Additional units will be considered if supported by documentation. Medical records must be submitted for review to substantiate payment for additional units.


**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 UHCCommunityPlan.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.