New Reimbursement Policies and Changes to Existing Reimbursement Policies


Effective for claims processed on or after Feb. 14, 2015, UnitedHealthcare Community Plan will make changes to these reimbursement policies.

- Anesthesia Policy
- Maximum Frequency Per Day Policy
- Services and Modifiers Not Reimbursable to Health Care Professionals Policy


Effective for claims with dates of service on or after Mar. 1, 2015, UnitedHealthcare Community Plan will implement two new reimbursement policies.

- Pediatric and Neonatal Critical and Intensive Care Services Policy
- One or More Sessions Policy

Reimbursement Policy Revision Delayed-

- Radiology Multiple Imaging Reduction Policy-Additional Reductions for Diagnostic Cardiovascular, Ophthalmology, & the Professional Component of Imaging Services Previously Announced

Anesthesia Policy:

The Anesthesia Policy currently denies anesthesia CPT codes 00100-01999 (excluding 01953 and 01996) identified as the direct or alternate crosswalk code within the ASA CROSSWALK® when reported by the physician who also reports the surgical or medical CPT procedure codes. UnitedHealthcare Community Plan will deny anesthesia CPT codes identified as direct or alternate anesthesia codes (CPT codes 00100-01999-excluding 01953 and 01996) when reported by the physician who also reports the surgical or medical Healthcare Common Procedure Coding System (HCPCS) procedure codes on the same date of service. For medical/surgical procedures reported as HCPCS codes, the direct and alternate crosswalk anesthesia CPT codes are obtained from CMS (Center for Medicare and Medicaid Services) NCCI edits and interpretation of other CMS sources.

Per the AMA, if a physician personally performs the regional or general anesthesia as well as the surgical procedure, modifier 47 should be appended to the surgical code and no codes from the Anesthesia section of the CPT code book should be used. Please refer to theAMA publication, Coding with Modifiers, fourth edition and the CPT Assistant Online Newsletter dated November 2006, page 23 for further information.
Note: This change will not apply to UnitedHealthcare Community Plan Medicare Dual Special Needs Plan (DSNP) products.

Maximum Frequency Per Day Policy:

Currently, UnitedHealthcare Community Plan’s Maximum Frequency per Day (MFD) Policy allows multiple units for procedure codes described as “per diem” or “per day” or when reported with a modifier 59 by network home health agencies and home health suppliers. Effective in the first quarter of 2015, the Maximum Frequency per Day (MFD) Policy will be revised to align with Current Procedural Terminology (CPT ®) and Healthcare Common Procedure Coding System (HCPCS) for procedure codes for services and supplies which state “per day” or “per diem” within the code description and allow one unit per day.

For example, the HCPCS description for S9501 is “Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem. If a patient requires twice daily home infusion antibiotic therapy, it would be appropriate to report one unit per day of HCPCS code S9501.

Codes with “per diem” or “per day” in their description should be reported with one unit for each date of service. If multiple dates of service are reported, each unit should be split out on a separate line with the corresponding date of service in order to be considered. There are no modifiers that will override the MFD value and it will be applied to all network and non-network physicians and other qualified health care professionals, home health agencies and home health suppliers.

For Mississippi, New Jersey and Pennsylvania, there are exceptions based on state regulations.

In addition, UnitedHealthcare Community Plan will be removing the Medically Unlikely Edits (MUE) content from the Maximum Frequency Per Day Policy which will be addressed in a new policy named Medically Unlikely Edits Policy.

Services and Modifiers Not Reimbursable to Health Care Professionals Policy:

To align with correct coding guidelines, UnitedHealthcare Community Plan will not reimburse modifiers 27, 73, and 74 when reported by physicians or other health care professionals on a CMS 1500 form or its electronic equivalent. These modifiers are for ambulatory surgery center (ASC) and hospital outpatient use only.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Multiple Outpatient Hospital E/M Encounters on the Same Date</td>
</tr>
<tr>
<td>73</td>
<td>Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia</td>
</tr>
<tr>
<td>74</td>
<td>Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia</td>
</tr>
</tbody>
</table>
Note: The denial of modifiers SE and SL will not apply to UnitedHealthcare Community Plan Medicaid products.

In addition, UnitedHealthcare Community Plan will not reimburse modifiers SE and SL when reported by physicians or other health care professionals. The use of these modifiers indicates that a service has been funded or a vaccine was been provided free of charge by the state or federal government; therefore, no cost has been incurred requiring reimbursement. Because of its dual description, ambulance transport codes reported with modifier SE will only be considered eligible for reimbursement when reported by ambulance providers.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SE</td>
<td>State and/or federally-funded programs/services; Ambulance transportation from Scene of accident or acute event to Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)</td>
</tr>
<tr>
<td>SL</td>
<td>State supplied vaccine</td>
</tr>
</tbody>
</table>

**Pediatric and Neonatal Critical and Intensive Care Services Policy:**

UnitedHealthcare Community Plan will implement a new policy that is supported by the American Medical Association’s (AMA) CPT instructions addressing reimbursement of certain Evaluation and Management (E&M) codes as well as non-E&M services when reported with pediatric and neonatal critical and intensive care E&M codes (99468–99476 and 99477–99480). In accordance with the AMA guidelines, UnitedHealthcare Community Plan will not reimburse certain E&M codes as well as those non-E&M services that are considered inclusive to the pediatric and neonatal critical and intensive care E&M codes. These edits will be applied when services are reported by physician(s) and/or health care professional(s) under the same Federal Tax ID number, regardless of specialty. Modifier overrides will be allowed as appropriate when supported by the AMA’s CPT and the CMS National Correct Coding Initiative (CCI) instructions for Medicaid.

Note: This new policy will not apply to UnitedHealthcare Community Plan Medicare Dual Special Needs Plan (DSNP) products.

**One or More Sessions Policy:**

UnitedHealthcare Community Plan will implement a new policy supported by CPT addressing reimbursement for procedures whose descriptions support payment only once within a defined treatment period. When a CPT code description includes the verbiage “one or more sessions” or “one or more stages,” it is understood that more than one encounter may be necessary to complete the treatment to achieve the desired outcome, with those encounters occurring within a defined treatment period. The defined treatment period for these services will mirror the global period assigned by CMS National Physician Fee Schedule Relative Value File. These codes will be reimbursed only once during the defined treatment period. Subsequent sessions reported during different encounters within this period will not be separately reimbursed, except when performed on a distinct and separate anatomical area and reported with an appropriate modifier.
In addition, the One or More Sessions policy will address reimbursement of cardiac device evaluation services whose descriptions state they are only to be reported once in a given monitoring period. Subsequent sessions reported during the monitoring period will not be reimbursed.

**Radiology Multiple Imaging Reduction Policy:**

To better align with Centers for Medicare and Medicaid Service (CMS), UnitedHealthcare Community Plan announced in a previous notification that an enhancement to the Radiology Multiple Imaging Reduction (RMIR) Policy to apply additional Multiple Procedure Payment Reductions (MPPR) to the professional component (PC) of Diagnostic Imaging procedures, and the technical component (TC) of Diagnostic Cardiovascular and Diagnostic Ophthalmology procedures would be implemented on or after Aug. 1, 2014. The implementation has been delayed until on or after March 1, 2015.

To promote transparency and ease in understanding across our commercial and government lines of business, UnitedHealthcare Community Plan will adopt the naming convention used by UnitedHealthcare’s Medicare Advantage in publishing these policies upon implementation.

- The existing Radiology Multiple Imaging Reduction Policy name will be changed to the Multiple Procedure Payment Reduction for Diagnostic Imaging.
- The MPPR reductions for the TC of Diagnostic Cardiovascular and Ophthalmology Procedures will be addressed within a new policy named Multiple Procedure Payment Reduction for Diagnostic Cardiovascular and Ophthalmology Procedures.

**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.