UnitedHealthcare Individual Exchange/Individual and Family Plans

Reimbursement Policy Update Bulletin: January 2026

New		
Policy Title	**Effective Date**	**Policy Summary**
Payment Reduction of Off-Campus Provider Based Departments Billed with Modifier PO Policy, Facility - Reminder	March 1, 2026	• Effective for dates of service on or after March 1, 2026, UnitedHealthcare will implement the new Payment Reduction of Off-Campus Provider-Based Departments Billed with Modifier PO Policy, Facility that will apply a 60% reduction when HCPCS code G0463 is reported with modifier PO, in alignment with the Centers for Medicare and Medicaid Services (CMS). • UnitedHealthcare will align with CMS and require that the HCPCS modifier PO be reported with outpatient hospital items and services in an off-campus provider-based department of a hospital. Provider-based departments of a hospital are owned and operated by a single entity known as the "main provider." They can be located on the same campus as the main provider or off-campus. A facility outside of 250 yards (from the main provider) but, within 35 miles, is considered off campus. • Consistent with CMS, reimbursement for G0463, when appropriately billed with modifier PO will be considered for reimbursement at 40% of the allowable amount. • The policy does not apply to the following facility types: o Services rendered in the Emergency Department o Critical Access Hospitals o Psychiatric, Rehabilitation, or Long-Term Care Hospitals or Hospital Units o Hospitals located in Maryland, Puerto Rico or the U.S. territories o Rural Sole Community Hospitals o Indian Health Service Hospitals
Routine Testing Management Policies – Professional and Facility	April 1, 2026 for NC and NE	Effective for dates of service on or after April 1, 2026, UnitedHealthcare will implement new Routine Testing Management Policies, Professional and Facility. These new reimbursement policies apply to specific laboratory services, tests, and procedures. The policies are available for review on the UnitedHealthcare Website, uhcprovider.com.

New		
Policy Title	**Effective Date**	**Policy Summary**
		Effective April 1, 2026, UnitedHealthcare will apply automated post-service, pre-payment policy enforcement to claims reporting laboratory services performed in office, hospital outpatient, and independent laboratory locations. These policies will provide guidelines around the circumstances and frequency for which claims for these tests will be considered for reimbursement. • These policies will not apply to laboratory services, tests, and procedures provided in emergency rooms, hospital observation units, and hospital inpatient settings. Routine Testing Management Policies: - Flow Cytometry Policy, Professional and Facility - Diabetes Mellitus Testing Policy, Professional and Facility - Iron Homeostasis and Metabolism Policy, Professional and Facility - Enzyme Testing for Acute Pancreatitis Policy, Professional and Facility - Prostate Biopsy Specimen Analysis Policy, Professional and Facility - Intestinal Dysbiosis and Fecal Microbiota Transplant Testing Policy, Professional and Facility - Diagnostic Testing for Influenza Policy, Professional and Facility - Homocysteine Testing for Metabolism Policy, Professional and Facility - Lyme Disease Testing Policy, Professional and Facility - Bone Turnover Marker Testing of Osteoporosis Policy, Professional and Facility - Fecal Calprotectin Testing Policy, Professional and Facility - Autoimmune Rheumatic Disease Policy, Professional and Facility - Diagnostic Testing for Inflammatory Bowel Disease Policy, Professional and Facility - Onychomycosis Testing Policy, Professional and Facility - Immune Cell Function Assay Policy, Professional and Facility - Chronic Heart Failure Policy, Professional and Facility - Epithelial Cell Cytology Policy, Professional and Facility - Intracellular Micronutrient Analysis Policy, Professional and Facility
Vitamin D Testing Policy, Professional and Facility	April 1, 2026	• Effective with dates of service on or after April 1, 2026, UnitedHealthcare will implement a new Vitamin D Testing Policy, Professional and Facility. • The policy will consider Vitamin D testing for reimbursement when submitted with an appropriate ICD-10 diagnosis and corresponding Vitamin D procedure code. The applicable codes will be listed in the policy. • Vitamin D tests that do not meet this criteria will be denied.

Revised		
Policy Title	**Effective Date**	**Summary of Changes**
Professional/Technical Component Policy, Professional	April 1, 2026	• Effective for dates of service on or after April 1, 2026, UnitedHealthcare will enhance the Professional/Technical Component Policy, Professional. When a radiology service is rendered and the physician or other eligible qualified healthcare professional performs a review rather than the full written interpretation and report, the reimbursement for the professional component is considered included in the Evaluation and Management (E/M) service. This will occur whether the radiology service is billed globally or with modifier 26. • Effective October 1, 2024, the Professional/Technical Component Policy was enhanced so the interpretation of a radiology service appended with modifier 26 would not be considered for separate reimbursement when reported on the same date of service as an E/M service for the same patient by the same provider unless a copy of the radiology report was attached to support separate reimbursement. • With the current enhancement, when a global radiology code is billed on the same date of service as an E/M service for the same patient, by the same individual provider, the global radiology code's professional component will not be considered for separate reimbursement unless a copy of the radiology report is attached to support separate reimbursement. o For example, if an internal medicine provider bills for an E/M service and a global radiology service, the provider would need to submit the report for the professional component of the global radiology service to be considered for separate reimbursement. • To help providers submit an interpretation report, a Smart Edit will be implemented which provides additional details regarding the process for submitting the full interpretation report.
Anatomical Modifier Requirement Policy, Professional - Reminder	February 1, 2026	Effective with dates of service on or after February 1, 2026, UnitedHealthcare will enhance the Anatomical Modifier Requirement Policy, Professional to align with the Center for Medicare and Medicaid Services (CMS) requirement that the appropriate laterality and/or anatomical modifiers be applied to surgical and radiological codes. • Surgical Codes (10000-69999 Series) o For codes related to a specific digit, the correct anatomical or laterality modifier must be used (FA, F1-F9, TA, T1-T9, LT, RT, 50). o For codes not related to a specific digit, the appropriate laterality modifier (LT, RT, 50) must be used when applicable. • Radiological Codes (70000 Series) o For codes related to a specific digit, the correct anatomical or laterality modifier must be used (FA, F1-F9, TA, T1-T9, LT, RT, 50). o For codes not related to a specific digit, the appropriate laterality modifier (LT, RT, 50) must be used when applicable. Modifiers play a critical role in medical coding by enhancing clarity and specificity. Submitting the appropriate modifiers to specify the exact area of the body where a procedure was performed helps eliminate the concern of duplicate billing and/or unbundling and helps ensure accurate reimbursement for the services rendered.

Revised

Policy Title	Effective Date	Summary of Changes
Diagnosis Code Requirement Policy, Professional and Facility – Reminder	March 1, 2026	• In the January 2024, Reimbursement Policy Update Bulletin, UnitedHealthcare (UHC) communicated implementation of a comprehensive Diagnosis Code Requirement Policy for both professional and facility services. This policy consolidated multiple diagnosis-related policies into one unified framework, aligning with existing ICD-10-CM guidelines. As part of that notification, UHC emphasized adherence by all providers to Excludes 1 coding rules, which are integral to the ICD-10-CM framework. At the time of the initial notification, these guidelines applied only to inpatient claims. • Excludes 1 guidelines indicate that certain codes are mutually exclusive, meaning they represent conditions that cannot be reported together—such as a congenital form versus an acquired form of the same condition. All providers must ensure compliance with Excludes 1 guidelines when submitting any type of claim. • UHC will begin enforcing the application of Excludes 1 guidelines across all claim types effective March 1, 2026, to include outpatient and professional claim types. For additional details, please refer to the updated Diagnosis Code Reimbursement Policy. • All providers must submit claims accurately in accordance with ICD-10-CM guidelines, including proper application of Excludes 1 rules. Claims that do not comply with these requirements may be subject to edits or denials.

Code Updates

Policy Title	Effective Date	Summary of Changes

Reimbursement Policy Code Updates – Multiple Policies	N/A	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.
		• The following UnitedHealthcare policies have recently been updated to include code changes:
		  • Professional/Technical Component, Professional
		  • Intracellular Micronutrient Analysis, Professional and Facility
		• 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.

Code Updates		
Policy Title	**Effective Date**	**Summary of Changes**
		• 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.

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 Individual & Family Plan Reimbursement Policies is available **UHCprovider.com** > Coverage and payments > Policies and protocols > For Individual Exchange Plans > Exchanges-Reimbursement-Policies .