Adjunct Services Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses 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.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

Each UnitedHealth Care Community Plan maintains a list of medical services that require authorization. It is the responsibility of the admitting facility, admitting or attending physician, surgeon, and/or primary provider of service to obtain the required authorization. Failure by a provider to obtain necessary authorization may result in a claim to deny for reimbursement.

Certain medical services performed by professional providers are an integral but separate adjunct component of an authorized or covered medical service. Separate adjunct medical services performed by an anesthesiologist, pathologist, radiologist or laboratory, when performed in combination with a covered inpatient admission, surgical procedure or other medical service will be considered for reimbursement regardless of the presence of an authorization (There may be State specific requirements for some radiology services.)

Reimbursement Guidelines
UnitedHealthcare Community Plan considers Adjunct Professional Services provided by network and non-network Anesthesiologists, Pathologists, Laboratory and /or Emergency (APLE) providers and network and non-network Radiology providers billing the Professional Component in either inpatient or outpatient places of service, (POS 19, 21, 22, or 24) to be reimbursable regardless of the presence of an authorization. Network Radiology providers billing the Global Service or the Technical Component in outpatient places of service must obtain authorization for services on the Prior Authorization List (PAL) found on the provider portal at uhcprovider.com Network providers, other than Radiologists, Anesthesiologists, Pathologists, and/or Laboratory (RAPL) providers, providing services in either inpatient or outpatient places of service (POS 19, 21, 22, or 24) must obtain authorization for services on the PAL found on the provider portal at https://www.uhcprovider.com/en/prior-auth-advance-notification.html Non-network providers, other than RAPL providers providing services in POS 21must obtain authorization for services. Reimbursement will be considered when there is an approved authorization for the inpatient stay. Non-network providers, other than RAPL providers, providing services in POS 19, 22, and 24 must obtain authorization for all services provided. Prior authorization is not needed for services provided in the Emergency Room (POS 23) or for Hospital Observation services identified by CPT codes 99217, 99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236, 99356, 99357, G0378 and G0379 when billed by network or non-network providers.

State Exceptions	
Ohio	Non-network RAPL providers will not be reimbursed if the hospital facility claim is denied for no authorization
Pennsylvania	Non-network providers, other than RAPL providers do not require authorization for consultation codes 99251, 99252, 99253, 99254, and 99255 when billed in POS 21
Tennessee	Non-network providers, other than RAPL providers do not require authorization for consultation codes 99251, 99252, 99253, 99254, and 99255 when billed in POS 21
Texas	Affiliated radiology services should require authorization in POS 24, either in conjunction with or separately from the index procedure for network and non-network Radiology providers High-dollar molecular diagnostic services and related pathology services require authorization for all places of service for network and non-network Pathology providers when the allowed amount is greater than $500. The list of codes can be found in the Attachments Section Effective 12/1/2018 for Texas Star and Star Kids, dental anesthesia CPT code 00170 when billed with any modifier for ages 7-20 requires authorization regardless of place of service. Effective 7/1/2017 for Texas Star and Star Kids, dental anesthesia CPT code 00170 when billed with any modifier for ages 0-6 requires authorization regardless of place of service

Definitions	
Adjunct Professional Provider	An anesthesiologist, pathologist, radiologist, or other healthcare professional who performs a medical service(s) as an adjunct to a primary covered service.

Adjunct Professional Service	A medical service performed by an anesthesiologist, pathologist, radiologist, or other healthcare professional that is an integral but separate adjunct component of an authorized or covered medical service.
Global Service	A Global Service includes both a Professional Component and a Technical Component. When a physician or other health care professional bills a Global Service, he or she is submitting for both the Professional Component and the Technical Component of that code. Submission of a Global Service asserts that the Same Individual Physician or Other Health Care Professional provided the supervision, interpretation and report of the professional services as well as the technician, equipment, and the facility needed to perform the procedure. In appropriate circumstances, the Global Service is identified by reporting the appropriate PC/TC split eligible procedure code with no modifier attached or by reporting a standalone code for global test only services.
PAL	Prior authorization list: list of services that require prior authorization be obtained before they are rendered. The list can be found on the provider portal at www.uhccommunityplan.com
Professional Component	The Professional Component represents the physician or other health care professional work portion (physician work/practice overhead/malpractice expense) of the procedure. The Professional Component is the physician or other health care professional supervision and interpretation of a procedure that is personally furnished to an individual patient, results in a written narrative report to be included in the patient's medical record, and directly contributes to the patient's diagnosis and/or treatment. In appropriate circumstances, it is identified by appending modifier 26 to the designated procedure code or by reporting a standalone code that describes the Professional Component only of a selected diagnostic test.
Technical Component	The Technical Component is the performance (technician/equipment/facility) of the procedure. In appropriate circumstances, it is identified by appending modifier TC to the designated procedure code or by reporting a Standalone Code that describes the Technical Component only of a selected diagnostic test.

Place of Service

POS	POS Name	POS Description
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Questions and Answers

1	**Q:** If a patient is admitted then has a surgical procedure performed that is listed on the prior authorization list (PAL) by a physician other than the attending, will the provider who performed the procedure be paid? **A:** Authorization requirements still apply for these services. The provider planning to do the procedure must obtain authorization in order for reimbursement to be made.
2	**Q:** Can the reimbursement to a provider for an adjunct service provided to UnitedHealthcare Community Plan enrollees vary? **A:** Yes, the reimbursement for an adjunct service can vary. This Adjunct Professional Service reimbursement policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees by Radiology, Anesthesia, Pathology/Lab and Emergency (RAPLE) providers. Other factors affecting reimbursement, including but not limited to legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents, including provisions addressing benefits for services rendered by non-participating providers, may supplement, modify or, in some cases, supersede this policy.
3	**Q:** If a patient is admitted and a provider other than the Attending Physician is called in, (for example a Consultant, Hospitalist, or other covering physician) would that provider be required to obtain an authorization? **A:** For inpatient services (POS 21) network and non-network providers other than the PCP or attending physician, are not required to obtain a separate, individual authorization unless they are providing a service listed on the current PAL. Non-network providers billing services not on the PAL will be considered for reimbursement when there is an approved authorization for the inpatient stay.

Texas High-Dollar Molecular Diagnostic and Related Pathology Services List:

List of CPT codes for Texas that require prior authorization for all places of service for network and non-network Pathology providers when the allowed amount is greater than $500.00

81161	81170	81200	81201	81202	81203	81205	81206	81207	81208
81209	81210	81218	81219	81223	81225	81226	81227	81228	81229
81235	81240	81241	81242	81243	81244	81245	81246	81250	81251
81252	81253	81254	81255	81256	81257	81260	81261	81262	81263
81264	81265	81266	81267	81268	81270	81272	81273	81275	81276
81287	81288	81290	81291	81292	81293	81294	81295	81296	81297
81298	81299	81300	81301	81302	81303	81304	81310	81311	81313
81314	81315	81316	81317	81318	81319	81321	81322	81323	81324
81325	81326	81330	81331	81332	81340	81341	81342	81350	81355
81370	81371	81372	81373	81374	81375	81376	81377	81378	81379
81380	81381	81382	81383	81400	81401	81402	81403	81404	81405
81406	81407	81408	81410	81411	81412	81415	81416	81417	81420
81425	81426	81427	81430	81431	81434	81435	81436	81437	81438
81440	81442	81445	81450	81455	81460	81465	81470	81471	81479
81490	81493	81500	81503	81504	81506	81507	81508	81509	81510
81511	81512	81519	81525	81528	81535	81536	81538	81540	81545
81595	81599								

Resources

Individual state Medicaid regulations, manuals & fee schedules

American Medical Association, *Current Procedural Terminology (CPT®) Professional Edition* and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

History	
9/1/2021	Annual Policy Version Change History prior to 9/1/2019 archived
5/19/2021	Policy Version Change Attachments section: Excel file converted to table
3/9/2020	Application Section: Removed Medicare Verbiage State Exceptions Section: Added exception for Tennessee
2/23/2020	Policy Version Change Attachments Section: Texas High-Dollar Molecular Diagnostic and Related Pathology Services List updated.
10/1/2019	Kansas State exceptions removed
9/6/2019	Annual Policy Version Change
1/1/2013	Policy implemented by UnitedHealthcare Community & State