

# Reimbursement Policy Updates for June 2019

## **Update to Procedure to Modifier Policy – Effective July 1, 2019**

We're updating the Procedure to Modifier Policy for claims with dates of service on or after July 1, 2019. Physical therapy (GP), occupational therapy (GO) or speech-language pathology (GN) modifiers will be required on Always Therapy codes to align with the Centers for Medicare & Medicaid Services (CMS).

CMS requires an Always Therapy code for certain services regardless of who performs them. CMS also requires a specific therapy modifier to indicate whether they're provided under a GN, GO or GP plan of care.

## **Update to CCI Editing Policy – Effective July 1, 2019**

We're updating the Correct Coding Initiative (CCI) Editing Policy for dates of services on or after July 1, 2019. To align with the CMS National Correct Coding Initiative Program (NCCI) transmittal update, we'll allow modifiers 59, XE, XP, XS and XU to be appended to either code in the column I/column II procedure-to-procedure (PTP) edits when a modifier override is allowed.

## **New Molecular Pathology Policy – Effective Sept. 1, 2019**

We're implementing a new Molecular Pathology Policy for dates of service on and after Sept. 1, 2019. The American Medical Association (AMA) guidelines provide claim designation codes in the Molecular Pathology Gene Table to represent specific genes that are being tested. We'll require you to append the AMA claim designation to identify the specific gene when submitting a Tier 2 Molecular Pathology code. If there's not a claim designation assigned, you should submit the abbreviated gene name. This can be found in the CPT® Molecular Pathology Gene Table. The specific analyte is also listed after each Tier 2 code descriptor.

Genomic Sequencing Procedures (GSP) panel codes account for specific combinations of genes for testing. Individual Molecular Pathology Tier 1 and Tier 2 codes shouldn't be submitted separately in addition to a GSP code. If Tier 1 or Tier 2 codes are submitted separately, they'll be denied. We may also deny Tier 1 and Tier 2 codes when there is a more appropriate GSP code available.

Additionally, unlisted code 81479 should only be submitted when the unique procedure is not adequately addressed by another CPT® code. It should only be submitted once per patient, per specimen and date of service.

We'll require the submission of a unique test ID provided through the National Institutes of Health Genetic Testing Registry (GTR) when 81479 is submitted to identify the test and validate that the unlisted code is the appropriate code to submit for the test performed.

The AMA claim designation code and the GTR unique test ID should be reported in loop 2400 or SV101-7 field for electronic claims and in box 19 for paper claims.

Claims submitted for services that have obtained advanced notification or prior authorization may meet these requirements by ensuring that the test information submitted to UnitedHealthcare Community Plan's Genetic Test Lab Registry meets these requirements.

## **New Mohs Micrographic (MMS) Surgery Policy – Effective Sept. 1, 2019**

We're implementing a new Mohs Micrographic Surgery (MMS) Policy for dates of service on and after Sept. 1, 2019.

According to CMS guidelines, Mohs surgery should only be performed by an MD or DO who is specifically trained and highly skilled in Mohs techniques and pathologic identification.

To maintain the quality of care and services delivered to our members, we'll only reimburse Mohs surgery to an MD or DO who is specifically trained in both dermatology and pathology. If either the removal of the tumor or the pathology is delegated to another physician or qualified health care professional not under the same tax ID number (TIN), the Mohs code will be denied.

CMS guidelines require that the pathology examination of the tissue specimen is an inclusive component of Mohs and shouldn't be reported separately. As such, we'll deny the pathology examination if separately reported.

#### **Update to Observation Care Evaluation and Management Codes Policy – Effective Sept. 1, 2019**

For dates of service on or after Sept. 1, 2019, we'll reimburse only one hospital discharge day CPT® code 99238 or 99239, per member, per hospital stay, to align with CMS guidelines.

Moving forward, the policy title will be revised to the Observation and Discharge Policy.

#### **Additional Information**

These policies apply to claims submitted for UnitedHealthcare Community Plan members on both paper CMS-1500 forms and Electronic Data Interface (EDI) transaction 837P claim files. To read the policies, please visit [UHCCommunityPlan.com](https://www.uhc.com/healthcare-professionals) > For Health Care Professionals > Select your state > Reimbursement Policies.

### **We're Here to Help**

If you have questions about policy updates, please contact your Network Account Manager or Provider Advocate. Thank you.

#### **Note About 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, these reimbursement policies apply to services reported using the CMS-1500 or its electronic equivalent, or its successor form.

UnitedHealthcare Community Plan reimbursement policies don't 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 Administrative Guide or Care Provider Manual. 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.

If there's an inconsistency or conflict between the information in this provider notification and the posted policy, the provisions of the posted reimbursement policy prevail.