United Healthcare

UnitedHealthcare Community Plan
Reimbursement Policy Update Bulletin: February 2021

New			
Policy title	**State(s)**	**Policy summary**	**Effective date**
Sexually Transmitted Infection Testing Policy, Professional and Facility	New Jersey	UnitedHealthcare Community Plan of New Jersey is implementing a new Sexually Transmitted Infection Testing Policy for professional and facility claims with dates of services on or after March 1, 2021. UnitedHealthcare Community Plan will reimburse for the following services to detect sexually transmitted infections (STIs) in men and women: **Single tests:** • 87491 – Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique • 87591 – Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhea, amplified probe technique • 87661 – Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, amplified probe technique **Comprehensive test:** • 87801 – Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms Procedure code 87801 is a more comprehensive, multiple organisms code for infectious agent detection by nucleic acid. When any 2 or more of the single test codes (87491, 87591 and/or 87661) are billed separately for the same provider and the same date of service, the reimbursement will be based on the rate for 87801, which is the more comprehensive, multiple organisms code. Regardless of the units billed for a single code, payment will be made based on a single unit of 87801.	March 1, 2021

New Jersey Perinatal Risk Assessment Facility and Professional Policy	New Jersey	The New Jersey Perinatal Risk Assessment (PRA) Policy, Facility and Professional, will be effective for claims with dates of service on or after Jan. 1, 2021. The PRA form is a uniform assessment tool to determine demographic, medical and psychosocial factors considered in the risk management of the pregnant individual. The PRA form was developed and piloted by a stakeholder task force, then introduced in 2009 as the uniform assessment tool for New Jersey. The current PRA Plus form was enhanced with additional fields relating to behavioral and psychosocial factors, alcohol and drug use, and COVID-19 related questions. The PRA Plus form is used to identify risk factors and, if needed, refer the pregnant individual to case management and/or community services through the SPECT system. Prenatal care providers are expected to complete a First Visit PRA Plus form during the first prenatal visit and a Third Trimester PRA Plus form during the third trimester of pregnancy. A PRA Plus Follow-Up form may be used to make updates to the First Visit form and can be completed until the Third Trimester form is started. Completed PRA Plus forms should be sent electronically to Family Health Initiatives (FHI) for data processing. In accordance with New Jersey State Law and Guidelines, an obstetrical provider, nurse, midwife or other licensed health care professional approved as a provider under the New Jersey FamilyCare Medicaid Fee for-Service (FFS) program is required to complete the First Visit PRA Plus form during a NJFC Medicaid beneficiary's first prenatal visit. Best practice requires that both the First Visit PRA Plus form and the Third Trimester PRA Plus form be completed and submitted timely during a NJFC Medicaid beneficiary's pregnancy. PRA data will be analyzed to identify trends in the risk factors associated with NJFC Medicaid beneficiaries during pregnancy. Effective for claims with service dates on or after Jan. 1, 2021, a provider shall not receive reimbursement for prenatal services provided to a pregnant NJFC Medicaid beneficiary until the First Visit PRA Plus form is submitted to FHI for that beneficiary.	March 1, 2021

Updated

Policy title	State(s)	Summary of changes	Effective date
Time Span Policy, Professional and Medically Unlikely Edits Policy, Professional	New York	UnitedHealthcare Community Plan of New York is updating the Time Span Policy and the Medically Unlikely Edits Policy, effective May 1, 2021: These policy enhancements will apply 5-year frequency limits for specified allergy testing codes, in accordance with New York State program requirements. The following allergy testing limits will apply:	May 1, 2021

		CPT® code — Number of tests eligible for reimbursement in a 5-year period ○ 95004 — 60 ○ 95017 — 60 ○ 95018 — 60 ○ 95024 — 40 ○ 95027 — 40 ○ 95028 — 40 ○ 95044 — 40 ○ 96003 — 30 **What this means for you** • When a code is billed with units exceeding the stated maximum, the units will be denied • This enhancement will be effective starting with dates of service May 1, 2021, and after	
Facility Billing Policy	Florida	Inpatient admissions effective Feb. 1, 2021, and after, per Florida State requirements, providers will follow the directive below when submitting Interim Claims for Inpatient members when the length of stay exceeds 100 days: 1. Providers will bill the first 100 days using: • Type of Bill (TOB) 112 (first interim claim) • Discharge Status should reflect member is still inpatient • Admission date to current date 2. Providers will bill for additional days after the initial billing using: • TOB 113 (continuing claim) • Discharge status that reflects member is still inpatient • Admission date to current date 3. Providers will bill the final claim using: • TOB 114 (discharge TOB) • Discharge status should reflect member has been discharged • Admission date to discharge date	February 1, 2021
Appropriate Patient Discharge Status for Type of Bill Policy, Facility	Florida	Inpatient admissions effective Feb. 1, 2021, and after, per Florida State requirements, providers will follow the directive below when submitting interim claims for inpatient members when the length of stay exceeds 100 days: 1. Providers will bill the first 100 days using:	February 1, 2021

		• Type of Bill (TOB) 112 (first interim claim) • Discharge status should reflect member is still inpatient • Admission date to current date 2. Providers will bill for additional days after the initial billing using: • TOB 113 (continuing claim) • Discharge status that reflects member is still inpatient • Admission date to current date 3. Providers will bill the final claim using: • TOB 114 (discharge TOB) • Discharge status should reflect member has been discharged • Admission date to discharge date	

Published reimbursement policies are intended to ensure reimbursement based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies may use 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.

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 Community Plan Reimbursement Policies is available at **UHCprovider.com** > Policies and Protocols > Community Plan Policies > Reimbursement Policies for Community Plan.