UnitedHealthcare®

July 2020

reimbursement policy update bulletin

UnitedHealthcare Commercial Reimbursement Policy Updates

Policy Title	Effective Date	Summary of Policy
NEW		
Outpatient Hospital Inappropriate Primary Diagnosis Policy, Facility*	10/1/2020	• The new Outpatient Hospital Inappropriate Primary Diagnosis Policy, Facility will be effective for dates of service on or after 10/1/2020. • This new policy will require an appropriate primary diagnosis code as published in the Official International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) guidelines, which is published on the Centers for Medicare and Medicaid (CMS) website. • ICD-10-CM specifies when a diagnosis code should never be listed as the primary diagnosis on an outpatient claim.
Outpatient Hospital Blood and Blood Products Policy, Facility*	10/1/2020	• The new Outpatient Hospital Blood and Blood Products Policy, Facility will be effective for dates of service on and after 10/1/2020. • In accordance with CMS guidelines, irradiation of a blood product code 86945 should not be reported in addition to HCPCS codes that include irradiated blood or blood products. Code 86945 should only be submitted when a specific irradiated blood or blood product HCPCS code does not exist. • To report transfusion services, the appropriate CPT code for the specific transfusion service provided should be submitted under revenue code 0391 (391) in addition to the code for the blood or blood product. • In alignment with CMS, HCPCS codes that include both the freezing or thawing of the blood or blood product and the blood or blood product itself should be submitted when available. A separate freezing or thawing procedure code should not be submitted in addition to the HCPCS code that includes these services. • A split unit of blood or blood product where portions are given to different patients or the same patient at different times utilizing code P9011 should be submitted with the appropriate revenue code that identifies the blood or blood product. Code 86985 for the splitting of the blood or blood product can be submitted in addition to P9011 when appropriate. • Following CMS and the Integrated OCE guidelines, when revenue code 0381 (381) or 0382 (382) are submitted the appropriate HCPCS code for packed red cells or whole blood must be submitted.

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NEW		

Outpatient Hospital Observation Policy, Facility*	10/1/2020	• The new Outpatient Hospital Observation Policy, Facility will be effective for dates of service on and after 10/1/2020.
		• The policy will enforce correct coding and billing guidelines associated with observation services in accordance with Centers for Medicare and Medicaid Services (CMS), the Integrated OCE (IOCE), and the CMS Hospital Outpatient Prospective Payment System (OPPS). Observation services not reported according to correct coding guidelines may be denied.
		• The following are correct coding guidelines for submitting observation services:
		  ○ Revenue code 0762 (observation hours) should be submitted with the appropriate HCPCS code.
		  ○ Type of bill 13X or 85X should be submitted.
		  ○ Observation services must be reported with units based on the hours the patient is under observation care.
		  ○ Observation services should only be submitted when they equal or exceed 8 hours (8 units)
		  ○ Observation services must be submitted on the same date of service or the day after one of the following:
		  ▪ Emergency Department Visit, Clinic Visit, Critical Care, or Direct Referral for Observation Care
		• When appropriate, Direct Referral for Observation may be submitted in addition to observation services.
		• Observation services must be reported on a single line and the date of service for that line is the date that the observation service begins.
		  ○ Observation services should not be reported with a date span even when the period of observation spans more than 1 calendar day.
		• Observation services should not be reported in addition to procedure codes that are assigned a status indicator of J1 or T when the procedure/service is reported on the same date of service or the day before observation services. Observation care is considered included in these procedures/services and is not separately reimbursed.

Policy Title	Effective Date	Summary of Changes
UPDATED		
Procedure to Modifier Policy, Professional	7/1/2020	• Effective with dates of service on or after July 1, 2020, the GN, GO, or GP modifiers will be required on "Always Therapy" codes to align with the Centers for Medicare and Medicaid (CMS). • According to CMS, certain codes are "Always Therapy" services regardless of who performs them, and always require a therapy modifier (GP, GO, or GN) to indicate that they are provided under a physical therapy, occupational therapy, or speech-language pathology plan of care. • "Always Therapy" modifiers are necessary to enable accurate reimbursement for each distinct type of therapy in accordance with member group benefits.

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Policy Title	Effective Date	Summary of Changes
UPDATED		
Emergency Department (ED) Facility Evaluation and Management (E/M) Coding Policy - Reminder	7/1/2017	• As part of the continued efforts to support accurate coding practices, UnitedHealthcare applies the Emergency Department (ED) Facility Evaluation and Management (E/M) Coding Policy for its commercial plans. The policy supports our commitment to the Triple Aim of improving health care services, health outcomes and overall cost of care. • UnitedHealthcare claims data has shown that the use of higher level E/M codes (99284 and 99285) for ED visits increased by more than 50 percent between 2007 and 2016. This policy focuses on facility ED claims that are submitted with level 4 (99284, G0383) and level 5 (99285, G0384) E/M codes. We developed the policy using our national experience to address inconsistencies in coding accuracy and the E/M coding principles created by the Centers for Medicare & Medicaid Services (CMS) that require hospital ED facility E/M coding guidelines to follow the intent of CPT® code descriptions and reasonably relate to a hospital's resource use. • As part of the policy implementation, we use the Optum Emergency Department Claim (EDC) Analyzer tool. The EDC Analyzer tool determines the appropriate E/M coding level based on data such as the patient's presenting problem, diagnostic services performed during the visit and associated patient Co-morbidities. To learn more about the EDC Analyzer tool, please visit EDCAnalyzer.com. • Facilities submitting claims for ED E/M codes may experience adjustments to level 4 or 5 E/M codes and payment based on the appropriate level E/M code or may receive a denial based on the reimbursement structure within their agreements with UnitedHealthcare. Facilities will have the opportunity to submit reconsideration or appeal requests if they believe a higher level E/M code is justified, in accordance with the terms of their contract and/or Administrative Guide. • As part of our ongoing deployment efforts we will be expanding this policy to all markets, with the exception of Hawaii, on October 1, 2020. Because it's important to us to support you with information about these policies, we have also added additional training material about the Policy and the EDC Analyzer Tool on UHCProvider.com/training.
Supply Policy, Professional	10/1/2020	• Effective for Dates of Service on or after October 1, 2020, separate reimbursement for anesthetic agents (Lidocaine, Marcaine, Bupivacaine, etc.) using J3490 and J3590 in POS 11 (office) will not be allowed. • Per the CMS NCCI Manual, these services are integral and not separately reimbursable from the main procedure.

*These reimbursement policies will also be implemented for UnitedHealthcare Oxford Health Plans on the listed effective date.

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.