October 2020

reimbursement policy update bulletin

UnitedHealthcare Commercial Reimbursement Policy Updates

Policy Title	Effective Date	Summary of Policy
UPDATED		
Telehealth and Telemedicine Policy, Professional*	1/1/2021	Effective with dates of service on and after Jan. 1, 2021, UnitedHealthcare will modify the Telehealth and Telemedicine Policy, including the following: • Eligible telehealth services will only be considered for reimbursement under this policy when reported with place of service (POS) 02. This is consistent with the Centers for Medicare and Medicaid (CMS) billing and reimbursement guidelines. Telehealth claims with any other POS will not be considered eligible for reimbursement. • Modifiers 95, GT, GQ or G0 may be appended to telehealth claims reported with POS 02, but the modifiers will be considered informational and not necessary to identify telehealth services. • UnitedHealthcare will consider the member's home as an originating site for eligible services. • Various codes will be eligible for consideration under the policy including codes listed in the current policy, as well as similar types of services rendered using interactive audio and video technology. • Certain physical, occupational and speech therapy (PT/OT/ST) telehealth services using interactive audio and video technology will be considered for reimbursement when rendered by qualified health care professionals. • The policy addresses additional provider-member electronic communication including virtual check-ins, remote patient monitoring and E-visits (non-face-to-face, member-initiated communications with providers using online patient portals). • Payment will align with applicable state law. We're Here to Help For additional telehealth resources, visit UHCprovider.com/telehealth.

Policy Title	Effective Date	Summary of Changes
UPDATED		
Laboratory Services Policy, Professional	1/1/2021	• Effective with dates of service on or after January 1, 2021, UnitedHealthcare will align with CMS and require surgical pathology for prostate needle biopsy specimens, including gross and microscopic examination, be reported with HCPCS code G0416 instead of 88305. • According to the CMS National Correct Coding Initiative (NCCI) Manual (Chapter 10), CMS requires that surgical pathology for all prostate needle biopsy specimens, including gross and microscopic examination, be reported with 1 unit of service and code G0416, instead of code 88305 and multiple units of service. • Claims for surgical pathology for prostate needle biopsy that do not align with the Laboratory Services Policy enhancement, because they are reported with code 88305, will be denied.

Policy Title	Effective Date	Summary of Changes
NEW		
Device, Implant, and Skin Substitute Policy, Facility*	1/1/2021	• The new Device, Implants, and Skin Substitutes Policy, Facility will be effective for dates of service on and after 01/01/2021. • For outpatient hospital services, the policy will describe correct coding and billing guidelines associated with Devices, Implants, and Skin Substitutes in accordance with CMS, the CMS Integrated Outpatient Code Editor (IOCE), and the Hospital Outpatient Prospective Payment System (OPPS). The following coding described for these claims include: ○ When a device dependent procedure is submitted, the device(s) necessary to the performance of the procedure should be submitted on the same claim and for the same date of service, unless in some cases the procedure was terminated. In the case of a terminated procedure the appropriate modifier must be appended to the procedure. ○ When an implanted device is submitted, the associated procedure code should be submitted on the same claim and for the same date of service. ○ When a skin substitute application or skin replacement procedure categorized as high or low cost is submitted, the skin substitute product that correlates to high or low cost should also be submitted on the same claim and for the same date of service. ○ When a device or implant was obtained by the provider at no cost or at a reduced cost it must be submitted with the appropriate condition code, value code, and modifier. • For inpatient and outpatient hospital services, the policy will outline the US Food and Drug Administration (FDA) definition for what is classified as an implant. ○ HCPCS codes reported under the revenue code for implants must meet the FDA product classification guidelines and definition for what is considered an implant.
Hospital Based Ambulance Policy, Facility*	1/1/2021	• The new Hospital Based Ambulance Policy, Facility will be effective for dates of service on or after 1/1/2021. • The purpose of this new policy is to align with CMS; to require the appropriate coding and billing of ambulance transportation services reported by institutionally based ambulance providers on a UB04 claim form or its electronic equivalent. • Correct coding and billing guidelines include: ○ Each ambulance transportation service must be reported with an ambulance modifier which is created by adding the origin and destination modifiers together. ○ Each ambulance transportation service must be reported with an ambulance revenue code and mileage HCPCS code. ○ Service units for each ambulance trip provided should always equal one. ○ Supplies are included in the base rate of the ambulance transportation services and not separately payable. • Institutionally based ambulance providers may provide transportation services directly or under an arrangement. The QM or QN modifiers distinguish between direct or arranged transportation services and must be reported in addition to the origin and destination modifiers.

*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.