UnitedHealthcare Individual Exchange/Individual and Family Plans

Reimbursement Policy Update Bulletin: December 2025

New		
Policy Title	**Effective Date**	**Summary of Changes**
Payment Reduction of Off-Campus Provider-Based Departments Billed with Modifier PO Policy, Facility	March 1, 2026	• Effective for dates of service on or after March 01, 2026, UnitedHealthcare will implement the new Payment Reduction of Off-Campus Provider-Based Departments Billed with Modifier PO Policy, Facility that will apply a 60% reduction when HCPCS code G0463 is reported with modifier PO, in alignment with the Centers for Medicare and Medicaid Services (CMS). • UnitedHealthcare will align with CMS and require that the HCPCS modifier PO be reported with outpatient hospital items and services in an off-campus provider-based department of a hospital. Provider-based departments of a hospital are owned and operated by a single entity known as the "main provider." They can be located on the same campus as the main provider or off-campus. A facility outside of 250 yards (from the main provider) but, within 35 miles, is considered off campus. • Consistent with CMS, reimbursement for G0463, when appropriately billed with modifier PO will be considered for reimbursement at 40% of the allowable amount. • The policy does not apply to the following facility types: o Services rendered in the Emergency Department o Critical Access Hospitals o Psychiatric, Rehabilitation, or Long-Term Care Hospitals or Hospital Units o Hospitals located in Maryland, Puerto Rico or the U.S. territories o Rural Sole Community Hospitals o Indian Health Service Hospitals
Individual and Exchange/Individual and Family Plans - Reminder	January 1, 2026	Effective for dates of service on or after January 1, 2026, New York and Massachusetts individual exchange/individual and family plans will be subject to the following additional reimbursement policies: • Appropriate Patient Discharge Status for Type of Bill Policy, Facility • Bilateral Procedures Policy, Facility

United Healthcare

New		
Policy Title	**Effective Date**	**Summary of Changes**
		• Facility Billing Policy, Facility • Hearing Aids Policy, Professional • Provider Preventable Conditions: Acquired Conditions Present on Admission Policy, Facility • Assistant-at-Surgery Services Policy, Professional

Revised		
Policy Title	**Effective Date**	**Summary of Changes**

Anatomical Modifier Requirement Policy, Professional – Reminder	February 1, 2026	Effective with dates of service on or after February 1, 2026, UnitedHealthcare will enhance the Anatomical Modifier Requirement Policy, Professional to align with the Center for Medicare and Medicaid Services (CMS) requirement that the appropriate laterality and/or anatomical modifiers be applied to surgical and radiological codes.
		• Surgical Codes (10000-69999 Series)
		  ○ For codes related to a specific digit, the correct anatomical or laterality modifier must be used (FA, F1-F9, TA, T1-T9, LT, RT, 50).
		  ○ For codes not related to a specific digit, the appropriate laterality modifier (LT, RT, 50) must be used when applicable.
		• Radiological Codes (70000 Series)
		  ○ For codes related to a specific digit, the correct anatomical or laterality modifier must be used (FA, F1-F9, TA, T1-T9, LT, RT, 50).
		  ○ For codes not related to a specific digit, the appropriate laterality modifier (LT, RT, 50) must be used when applicable.
		
		Modifiers play a critical role in medical coding by enhancing clarity and specificity. Submitting the appropriate modifiers to specify the exact area of the body where a procedure was performed helps eliminate the concern of duplicate billing and/or unbundling and helps ensure accurate reimbursement for the services rendered.

Diagnosis Code Requirement Policy, Professional and Facility	March 1, 2026	• In the January 2024, Reimbursement Policy Update Bulletin, UnitedHealthcare (UHC) communicated implementation of a comprehensive Diagnosis Code Requirement Policy for both professional and facility services. This policy consolidated multiple diagnosis-related policies into one unified framework, aligning with existing ICD-10-CM guidelines. As part of that notification, UHC emphasized adherence by all providers to Excludes 1 coding rules, which are integral to the ICD-10-CM framework. At the time of the initial notification, these guidelines applied only to inpatient claims. • Excludes 1 guidelines indicate that certain codes are mutually exclusive, meaning they represent conditions that cannot be reported together—such as a congenital form versus an acquired form of the same condition. All providers must ensure compliance with Excludes 1 guidelines when submitting any type of claim. • UHC will begin enforcing the application of Excludes 1 guidelines across all claim types effective March 1, 2026, to include outpatient and professional claim types. For additional details, please refer to the updated Diagnosis Code Reimbursement Policy.

Revised		
Policy Title	**Effective Date**	**Summary of Changes**
		• All providers must submit claims accurately in accordance with ICD-10-CM guidelines, including proper application of Excludes 1 rules. Claims that do not comply with these requirements may be subject to edits or denials.

Code Updates		
Policy Title	**Effective Date**	**Summary of Changes**

Reimbursement Policy Code Updates – Multiple Policies	N/A	In response to provider feedback and in an effort to provide more transparency, UnitedHealthcare is providing additional information regarding code updates that impact reimbursement policies. These updates are not changing the intent or the coding requirements of the policy, but reflect changes made to industry standard code sets.
		
		• The following UnitedHealthcare policies have recently been updated to include code changes:
		  ◦ Add-On Codes, Professional
		  ◦ MPPR for Medical and Surgical Services Policy, Professional
		  ◦ Maximum Frequency per Day, Professional
		
		• Information regarding these code updates can be found in the history section which is located at the end of the posted policy.
		
		• Code sections/lists/tables within a policy may not be comprehensive but may be provided as examples. Please review the full policy to understand applicability.
		
		• Code updates could include, for example, CPT, HCPCS, ICD-10, Modifiers, Revenue Codes, or other industry standard code sets.
		
		• UnitedHealthcare routinely updates its reimbursement policies in response to code updates made by, for example, Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), and the World Health Organization (WHO). This information is provided as a courtesy and may not include all code updates.

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 Individual & Family Plan Reimbursement Policies is available **UHCprovider.com** > Coverage and payments > Policies and protocols > For Individual Exchange Plans > Exchanges-Reimbursement-Policies .