United Healthcare

UnitedHealthcare Community Plan
Reimbursement Policy Update Bulletin: April 2025

New

Policy Title	State(s)	Policy summary	Effective Date
Radiation Therapy – Dosimetry, Simulation/Devices and Management Policy, Professional and Facility	Indiana	• Effective for dates of service on or after May 1, 2025, UnitedHealthcare will implement the new Radiation Therapy – Dosimetry, Simulation/Devices and Management Policy, Professional and Facility. • Radiation therapy dosimetry, simulation, and management services, identified with select CPT® codes, will have unit limitations during a 90-day episode of care, as noted below. Units billed in excess of the reimbursable units will not be considered for reimbursement.	May 01, 2025

Procedure Code	Reimbursable Units	Descriptions	Treatment Description
77280	4	Therapeutic radiology simulation-aided field setting; simple	Simulation
77285	2	Therapeutic radiology simulation-aided field setting; intermediate	Simulation
77290	3	Therapeutic radiology simulation-aided field setting; complex	Simulation
77295	2	3-dimensional radiotherapy plan, including dose-volume histograms	3-D Radiotherapy
77300	10	Basic radiation dosimetry calculation	Basic Dosimetry
77301	5	Intensity modulated radiotherapy plan, including dose-volume histograms	IMRT Dose Planning
77332	10	Treatment devices, design and construction; simple	Treatment Devices
77333	10	Treatment devices, design and construction; intermediate	Treatment Devices
77334	10	Treatment devices, design and construction; complex	Treatment Devices
77338	5	Multi-leaf collimator (MLC) design and construction per IMRT plan	MLT Device for IMRT
77427	9	Radiation treatment management, 5 treatments	Radiation Therapy Treatment Mgmt
77431	1	Radiation therapy management with complete course of therapy	Radiation Therapy Treatment Mgmt
77435	1	Stereotactic body radiation therapy, treatment management	Radiation Therapy Treatment Mgmt

- These limits apply only to codes for the dosimetry, simulation, and management aspect of radiation therapy treatment planning and not to radiation therapy treatment itself.
- A 90-day episode of care begins when one of the therapeutic radiology treatment planning CPT® codes (77261, 77262, and 77263) are billed. A new episode of care begins again if a radiation treatment planning code is submitted before the previous 90-day episode of care ends.

<table>
<tr>
<td>Radiation Therapy – Dosimetry, Simulation/Devices and Management Policy, Professional and Facility - Reminder</td>
<td>Massachusetts
Michigan
New Mexico
Rhode Island
Virginia
Washington DC</td>
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Revised

Policy Title	State(s)	Summary of Changes	Effective Date
Modifier Policy, Facility	Texas	• The new Modifier Policy, Facility, will be effective July 01, 2025, for dates of service on or after October 25, 2024. • In alignment with the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS), modifier 53 is not appropriate for reporting on a UB-04 claim form. Therefore, United Healthcare Community Plan will deny the claim line reported with modifier 53 on outpatient facility claims.	July 01, 2025

Anatomical Modifier Requirement Policy, Professional	Kansas	• Effective for dates of service on or after May 01, 2025, UnitedHealthcare Community Plan will align with CMS by creating a new professional Anatomical Modifier Requirement Policy which will provide correct coding requirements for appending anatomical modifiers to CPT codes representing percutaneous coronary intervention procedures. The following modifiers are used to identify the different digit or limb, vessel, or side of the body where a specific procedure is performed: o LC o LD o LM o RC o RI	May 01, 2025
Anatomical Modifier Requirement Policy, Professional	Kansas	• Effective for dates of service on or after May 01, 2025, UnitedHealthcare Community Plan will enhance the Anatomical Modifier Requirement Policy, Professional to require the use of appropriate laterality or anatomical modifiers for surgical procedures assigned a bilateral status indicator of 1 on the CMS National Physician Fee Schedule for the claim to be considered for reimbursement. • Claim lines not reported with the appropriate laterality or anatomical modifier (50, LC, LD, LM, RC, RI, E1-E4, FA, F1-F9, LT, RT, TA, T1-T9) will be denied.	May 01, 2025
Home Health Services Policy, Professional	Kansas	• Effective for dates of service on or after May 01, 2025, UnitedHealthcare Community Plan will implement the new Home Health Services Policy, Professional. • In alignment with CMS, home health services billed in place of service 12 will not be reimbursed if the dates of service overlap with an inpatient stay. The date span criteria will exclude the date of admission and discharge.	May 01, 2025
Modifier Policy, Facility	Kansas	• The new Modifier Policy, Facility, will be effective for dates of service on or after May 01, 2025. • In alignment with the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS), modifier 53 is not appropriate for reporting on a UB-04 claim form. Therefore, United Healthcare Community Plan will deny the claim line reported with modifier 53 on outpatient facility claims.	May 01, 2025

Discarded Drugs and Biologicals Policy, Professional and Facility- Reminder	Maryland	• Effective for dates of service on or after May 1, 2025, United Healthcare will align with the Centers from Medicare and Medicaid (CMS) requirement for reporting the JZ modifier for a Professional claim to be considered for reimbursement. • In accordance with CMS Medicare Claims Processing Manual Chapter 17 (Section 40) providers and suppliers are required to report the JZ modifier to attest that no amount of drug or biological from a single-dose container or a single-use package was unused or discarded for which the JW modifier would be required if there were discarded amounts.	May 01, 2025
Ambulance Policy, Professional - Reminder	New Jersey Texas	• Effective for dates of service on or after June 1, 2025, UnitedHealthcare will enhance the new Ambulance Policy, Professional. • In alignment with CMS, ambulance services to and from an originating facility to another facility for services such as diagnostic tests or specialty treatment will not be reimbursed if the date(s) of service overlap with an inpatient stay. The date span criteria will exclude the date of admission and discharge.	June 01, 2025
Device and Skin Substitute Policy, Facility – Reminder	Texas	• UnitedHealthcare Community Plan will align with CMS by creating a new Device and Skin Substitute Policy, Facility that will be effective for dates of service on or after June 1, 2025. • When a device- dependent procedure code is submitted, the appropriate device code must be submitted on the same claim for the same date of service unless the procedure was terminated. • The submission of certain skin substitute application procedures requires the appropriate skin substitute product be submitted on the same day. These procedures and products are divided into two lists based on high or low cost.	June 01, 2025
Home Health Services Policy, Professional - Reminder	Texas	• Effective May 01, 2025, for dates of service on or after December 20, 2024, UnitedHealthcare Community Plan will implement the new Home Health Services Policy, Professional. • In alignment with CMS, home health services billed in place of service 12 will not be reimbursed if the dates of service overlap with an inpatient stay. The date span criteria will exclude the date of admission and discharge.	May 01, 2025

Anatomical Modifier Requirement Policy, Professional - Reminder	Texas	• Effective May 01, 2025, for dates of service on or after December 20th, 2024; The new Anatomical Modifier Requirement Policy, Professional will be effective. • UnitedHealthcare will align with CMS by creating a new professional Anatomical Modifier Requirement Policy which will provide correct coding requirements for appending anatomical modifiers to CPT codes representing percutaneous coronary intervention procedures. The following modifiers are used to identify the different digit or limb, vessel, or side of the body where a specific procedure is performed: o LC o LD o LM o RC o RI	May 01, 2025
Anatomical Modifier Requirement Policy, Professional - Reminder	Texas	• Effective May 01, 2025, for dates of service on or after December 20th, 2024; UnitedHealthcare Community Plan will enhance the Anatomical Modifier Requirement Policy, Professional to require the use of appropriate laterality or anatomical modifiers for surgical procedures assigned a bilateral status indicator of 1 on the CMS National Physician Fee Schedule for the claim to be considered for reimbursement. • Claim lines not reported with the appropriate laterality or anatomical modifier (50, LC, LD, LM, RC, RI, E1-E4, FA, F1-F9, LT, RT, TA, T1-T9) will be denied.	May 01, 2025

Outpatient Medical Visits and Trauma Activation, Facility – Reminder	Kansas	• Effective for dates of service on or after May 01, 2025, UnitedHealthcare Community Plan will align with CMS by creating a policy to address Outpatient Medical Visits and Trauma Activation HCPCS code G0390. o When distinct and independent medical visits occur on the same date of service under the same revenue code condition code G0 must be submitted. Multiple visits meeting these criteria that are submitted without condition code G0 are not separately reimbursable. o A separately identifiable status indicator V evaluation and management (E/M) code can be submitted on the same date of service as a procedure that has a status indicator of S or T if a modifier is appropriately applied. In these circumstances it would be appropriate to append modifier 25 to the E/M code to indicate the E/M service performed was separate and distinct. o Trauma activation is considered a one-time occurrence in association with critical care service. Therefore, only one unit of G0390 is reimbursable per date of service. • Trauma activation code G0390 can be submitted separately under revenue code 68X (068X) when provided on the same date of service as critical care service 99291.	May 01, 2025
Outpatient Medical Visits and Trauma Activation, Facility – Reminder	Texas	• Effective May 01, 2025, for dates of service on or after December 20th, 2024; UnitedHealthcare Community Plan will align with CMS by creating a policy to address Outpatient Medical Visits and Trauma Activation HCPCS code G0390. o When distinct and independent medical visits occur on the same date of service under the same revenue code condition code G0 must be submitted. Multiple visits meeting these criteria that are submitted without condition code G0 are not separately reimbursable. o A separately identifiable status indicator V evaluation and management (E/M) code can be submitted on the same date of service as a procedure that has a status indicator of S or T if a modifier is appropriately applied. In these circumstances it would be appropriate to append modifier 25 to the E/M code to indicate the E/M service performed was separate and distinct. o Trauma activation is considered a one-time occurrence in association with critical care service. Therefore, only one unit of G0390 is reimbursable per date of service. • Trauma activation code G0390 can be submitted separately under revenue code 68X (068X) when provided on the same date of service as critical care service 99291.	May 01, 2025

Rebundling Policy, Professional – Reminder	Texas	• Effective May 01, 2025, for dates of service on or after December 20th, 2024; HCPCS code G2211 will be included within the UnitedHealthcare Community Plan Rebundling Policy, Professional. • UnitedHealthcare's Community Plan reimbursement for the services associated with G2211 is included in its reimbursement for outpatient evaluation and management services and therefor G2211 is not separately reimbursable.	May 01, 2025

Code Update			
Policy Title	**State(s)**	**Summary of Changes**	**Effective Date**

Reimbursement Policy Code Updates – Multiple Policies	Multiple	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.
		• 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.
		• Check published policy to determine impact at the state level.
		• The following UnitedHealthcare policies have recently been updated to include code changes:
		  • Age to Diagnosis Code and Procedure Code Policy, Professional
		  • Ambulance Services, Professional
		  • Appropriate Patient Discharge Status for Type of Bill Policy, Facility
		  • Assistant-at-Surgery Services, Professional
		  • B Bundle, Professional
		  • CCI Editing, Professional
		  • Drug Testing Reimbursement Policy, Professional
		  • Facility Billing
			April 01, 2025

Code Update			
Policy Title	**State(s)**	**Summary of Changes**	**Effective Date**
		• From - To Date, Professional • Gender to Procedure and Diagnosis, Professional • Home Health Services, Professional • Inappropriate Primary Diagnosis Codes Policy, Professional (Louisiana Only) • Laboratory Services, Professional • Maximum Frequency per Day CPT, Professional • Maximum Frequency per Day HCPCS, Professional • MPPR for Medical and Surgical Services Policy, Professional • Non-Covered and Covered Codes Policy, Facility • Non-Covered and Covered Codes Policy, Professional • Nonphysician Health Care Professionals Billing E/M Codes, Professional • Obstetrical Services, Professional • Preventive Medicine and Screening, Professional • Procedure and Place of Service, Professional • Procedure to Modifier, Professional • Professional/Technical Component, Professional • Provider Specialty Crosswalk • Replacement Codes Policy, Professional • Services and Modifiers Not Reimbursable to Health care Professionals Policy, Professional • Telehealth/Virtual Health Policy, Professional • Telehealth/Virtual Health Policy, Professional and Facility • Unlisted Services Policy, Professional • Vaccines For Children Policy, Professional	

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.