One or More Sessions Policy

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed 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.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, the enrollee's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

Application

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

Certain Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) code descriptions support reimbursement only once during the Defined Treatment Period. Per CPT, these codes include treatment at one or more sessions that may occur at different patient encounters. These codes should only be reported once during the Defined Treatment Period unless reported with an appropriate modifier.

For the purposes of this policy, the Same Physician or Other Health Care Professional includes physicians and/or other health care professionals of the same group and same specialty reporting the same Federal Tax Identification number.

Reimbursement Guidelines

UnitedHealthcare will reimburse a CPT or HCPCS code only once during the Defined Treatment Period.

The Defined Treatment Period mirrors the National Physician Fee Schedule (NPFS) global fee period.

National Physician Fee Schedule

Multiple submissions of the same CPT or HCPCS code by the Same Physician or Other Health Care Professional for the same patient during the Defined Treatment Period will be denied as part of the global service unless an appropriate

modifier is reported. Refer to the Modifiers and Attachments sections of this policy.

Services addressed in the One or More Sessions Policy may also be subject to global surgical package guidelines. Please refer to the Global Days policy for additional information.

Modifiers

Modifiers offer the physician or healthcare professional a way to identify that a service or procedure has been altered in some way. Under appropriate circumstances, modifiers should be used to identify unusual circumstances, staged or related procedures, distinct procedural services or separate anatomical location(s).

UnitedHealthcare recognizes the following designated modifiers, when appropriately reported, under this reimbursement policy:

LT, RT, 50, 52, 53, 54, 55, 56, 79

Definitions

Same Specialty Physician or Other Qualified Health Care Professional	Physicians and/or other qualified health care professionals of the same group and same specialty reporting the same Federal Tax Identification number.
Defined Treatment Period	The timeframe that corresponds with the global fee period assigned to a code on the National Physician Fee Schedule Relative Value File. The global fee period is the number of days during which all necessary services normally furnished by a physician (before, during, and after the procedure) are included in the reimbursement for the procedure performed.

Questions and Answers

1	**Q:** What happens if the Same Physician or Other Health Care Professional had to discontinue or reduce the first surgery, but was able to complete the surgery the second time within the same Defined Treatment Period? **A:** If the first surgical procedure was reported with a modifier 52 or 53, upon submission of a second unmodified global code within the same Defined Treatment Period, the partial reimbursement will be adjusted and the global code will be reimbursed.
2	**Q:** What happens if the Same Physician or Other Health Care Professional performs the surgery on one eye then performs the surgery on the other eye two weeks later (within the same Defined Treatment Period)? **A:** In this case, it is critical that the anatomic modifiers (LT and/or RT) be used appropriately to indicate the eye upon which the surgery was performed with each submission. The subsequent procedure will be considered for reimbursement when appropriate modifiers are reported.
3	**Q:** What happens if a different surgeon performs subsequent surgeries in the same Defined Treatment Period? **A:** If the Same Specialty Physician or Other Qualified Health Care Professional is reporting with the same Federal Tax Identification number (TIN), subsequent surgeries will be denied within the same Defined Treatment Period. If the physician or other health care professional is a different specialty and/or different TIN, subsequent surgeries will be considered for reimbursement.
4	**Q:** When does the Defined Treatment Period of a procedure begin and end? **A:** The Defined Treatment Period begins the day of the procedure and then 10 or 90 days before the procedure and following the procedure, beginning the first day of the procedure. Example: A procedure having a Defined Treatment Period of 90 days is performed on 10/1. Procedures reported on 10/1 and during the 90-day treatment period before and after (7/3 through and including 12/30) are included in the treatment period.

Codes

Modifiers	
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)
50	Bilateral procedure
52	Reduced services
53	Discontinued procedure
54	Surgical care only
55	Postoperative management only
56	Preoperative management only
79	Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period

Attachments	
One or More Sessions List	A list of codes with a defined treatment period.

Resources
American Medical Association, *Current Procedural Terminology* (CPT®) and associated publications and services

History	
7/5/2019	Annual Anniversary Date and Version Change Title section: Removed Annual Approval information & moved policy # to the header
7/11/2018	Annual Approval Date and Version Change Removal of “Monitoring” from verbiage
3/11/2018 – 7/10/2018	Annual Policy Version Change Policy List Change: Once per 30 days and Once per 90 days codes removed, Q&A #4 removed, Q&A #5 updated and re-numbered. Entries prior to 1/1/2016 archived
7/12/2017	Policy Approval Date Change, Logo, Preamble and Footer have been updated. (no new version)
1/1/2017 – 3/10/2018	Annual Policy Version Change Policy List Change: updated Entries prior to 1/1/2015 archived