ONE OR MORE SESSIONS POLICY

Policy Number: ADMINISTRATIVE 242.12 T0 **Effective Date**: November 1, 2018

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Related Policy

Refer to the Reimbursement Guidelines section of the policy

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

APPLICATION

This reimbursement policy applies to services reported using the UB-04 claim form, the 1500 Health Insurance Claim Form (a/k/a CMS-1500), or their electronic equivalents or their successor forms. This policy applies to all network and non-network providers, including Hospitals, Ambulatory Surgical Centers, Physicians and Other Health Care Professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

OVERVIEW

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

For the purposes of this policy, the Same Physician, Hospital, Ambulatory Surgical Center or Other Health Care Professional includes Physicians, Hospitals, Ambulatory Surgical Centers and/or Other Health Care Professionals of the same group and same specialty reporting the same Federal Tax Identification number.

REIMBURSEMENT GUIDELINES

Oxford 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.
Multiple submissions of the same CPT or HCPCS code by the Same Physician, Hospital, Ambulatory Surgical Center 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, hospital, ambulatory surgical center 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).

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

Modifier	Description
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 left 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

DEFINITIONS

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.

Same Specialty Physician, **Hospital, Ambulatory Surgical Center or Other Health Care Professional**: Physicians, Hospitals, Ambulatory Surgical Centers and/or Other Health Care Professionals of the same group and same specialty reporting the same Federal Tax Identification number.

QUESTIONS AND ANSWERS

1	**Q:**	What happens if the Same Physician, Hospital, Ambulatory Surgical Center 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, Hospital, Ambulatory Surgical Center 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, Hospital, Ambulatory Surgical Center or Other 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, hospital, ambulatory surgical center 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.

ATTACHMENTS

One or More Sessions Policy List

A list of codes with a Defined Treatment Period

One or More Sessions Policy List

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Payment Policy Oversight Committee. [*2018R0118B*]

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

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description

11/01/2018	• Reformatted references to related Reimbursement Policies
	• Revised reimbursement guidelines; removed language pertaining to the Monitoring Period
	• Removed definition of "Monitoring Period"
	• Updated Questions and Answers (Q&A):
	  ○ Removed Q&A pertaining to reimbursement for CPT codes 93295 and 93296
	  ○ Modified Q&A #4:
	  ▪ Removed references to "Monitoring Period"
	  ▪ Revised language to indicate 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
	• Revised *One or More Sessions Policy List* (attachment file listing procedure codes with a Defined Treatment Period); removed HCPCS code A0000
	• Archived previous policy version ADMINISTRATIVE 242.11 T0