FROM – TO DATE POLICY

Policy Number: ADMINISTRATIVE 223.19 T0 **Effective Date**: January 1, 2019

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Related Policies

- 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 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. With the exception of home health care, home infusion, durable medical equipment, orthotics and prosthetics suppliers, due to their monthly billing requirements unless the code description for the service or supply indicates it should be reported only once daily, this policy applies to all products and 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 health care professionals.

This policy also does not apply to Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes reported for time based anesthesia services, codes with a time span in their description, unlisted codes, global maternity codes, drugs, and ambulance mileage.

OVERVIEW

When Grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. Grouping is allowed only for identical services on consecutive days. In those instances

where Grouping of services applies, the number of units submitted should be equally divided by the number of days indicated in the 'from' and 'to' dates reported.

REIMBURSEMENT GUIDELINES

The National Uniform Claim Committee (NUCC) develops and oversees the NUCC Data Set (NUCC-DS), which is a standardized data set for use in an electronic environment, but applicable to and consistent with evolving paper claim form standards. The *NUCC 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12* provides instruction for the completion of the 1500 Health Insurance Claim form. This manual includes the following instruction for entering the dates of service:

- "If there is only one date of service, enter that date under 'From'. Leave 'To' blank or re-enter 'From' date."
- "If Grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in 24G.

The Centers for Medicare and Medicaid Services (CMS) *Medicare Claims Processing Manual Chapter 26*, also states: "When 'from' and 'to' dates are shown for a series of identical services, enter the number of days or units in column G." CMS returns a claim as unprocessable if a date of service extends more than 1 day and a valid "to" date is not present.

Consistent with NUCC and CMS, Oxford will only consider reimbursement for claim lines, with a 'from' and 'to' date span greater than one day, when the units entered correspond or are equally divisible to the number of days indicated. Claim lines for which the 'from' and 'to' dates and units do not correspond, or are not equally divisible by the number of days indicated, will not be processed. The services will need to be resubmitted on separate claim form lines with the units matching the corresponding from and to dates.

An example of a claim form submission where the service dates cannot be determined and therefore the claim cannot be processed:

Code	Modifier	Units	From Date	To Date
99213	-	3	02/10/2009	03/19/2009

The claim should be submitted as follows:

Code	Modifier	Units	From Date	To Date
99213	-	1	02/10/2009	02/10/2009
99213	-	1	02/25/2009	02/25/2009
99213	-	1	03/19/2009	03/19/2009

Oxford recognizes there are exceptions to this policy based on the uniqueness of some CPT and HCPCS codes reported for services rendered. The following types of services are exempt from this policy:

- Certain CPT® and HCPCS codes, based on their description, are not intended to be reported on consecutive dates of service, but may be appropriate to report with a 'from' and 'to' date. For example, codes whose descriptions say per week, per month, per course of treatment would be considered exceptions to this policy. Refer to the policy titled *Time Span Codes* for additional information.
- Codes that represent drugs or contrast and radiopharmaceutical imaging materials
- Global maternity codes. Refer to the *Obstetrical Policy*.
- Time based anesthesia codes
- Unlisted codes

For a complete list of codes exempt from this policy, please see the Attachments below.

As stated in the Application section of this policy, home health care, home infusion, durable medical equipment, orthotics and prosthetics suppliers are excluded from this policy unless they report a code that by description indicates it should be reported only once daily. For example, HCPCS code S9328 [Home infusion therapy, implanted pump pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), **per diem**] describes services that would be reported once per day, therefore, units billed should correspond to 'from' and 'to' dates.

Refer to the Attachments section below for a listing of codes that describe 'per diem' or 'per day' services that are not excluded from this policy when billed by home health care, home infusion, durable medical equipment, orthotics and prosthetics suppliers.

DEFINITIONS

Grouping: Grouping refers to the reporting of services which share a procedure code, place of service, charge and individual provider. The services must have been provided on consecutive days and the number of days must correspond to the number of units reported in field 24G of the 1500 Health Insurance Claim Form.

QUESTIONS AND ANSWERS

1	**Q:**	What fields on the 1500 claim form are you referencing for the "Days or Units" and, "From" and "To" date?
	A:	These claim form fields on the 1500 claim form are identified as follows: • **Paper Claims with CMS Paper Format 02-12**: The "From" and "To" dates are entered in 24A DATE(S) OF SERVICE field. "Days or Units" are entered in field 24G DAYS OR UNITS field for each applicable service line. For additional information, refer to the National Uniform Correct Coding (NUCC) Website: www.nucc.org. • **Electronic Claims**: Reference the Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines, electronic claims submitted via the 837 Professional transaction set or the NUCC website, which provides a 1500-837p crosswalk.

ATTACHMENTS

From-To Policy Exceptions List

A list of codes for services exempt from this policy

From - To Policy Exceptions List

From-To Date Policy Per Diem Per Day List

A list of services and supplies to be reported only once daily

From-To Date Policy Per Diem Per Day 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. [*2018R0113C*]

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

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets.

National Uniform Claim Committee (NUCC).

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
01/01/2019	• Updated *From - To Policy Exceptions List* (CPT/HCPCS codes for services exempt from this policy) to reflect annual code edits: ○ Added 0533T, 0534T, 0535T, 0536T, 93264, 95836, 99091, 99454, 99457, 99491, A9589, B4105, E0447, E0467, J0185, J0517, J0567, J0584, J0599, J0841, J1095, J1301, J1454, J1628, J1746, J2062, J2186, J2787, J2797, J3245, J3304, J3316, J3397, J3398, J3591, J7170, J7177, J7203, J7318, J7329, J9044, J9057, J9153, J9173, J9229, J9311, J9312, L8608, L8698, L8701, Q2042, Q4202, Q5107, Q5109, and Q5111 ○ Removed J0833, J9310, K0903, Q9993, and Q9995 • Archived previous policy version ADMINISTRATIVE 223.18 T0