Oscar reimbursement policies.

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2021 Oscar Reimbursement Policies

Inpatient Consultations

Policy

An inpatient consultation is a service provided by a physician or health care professional whose opinion or advice is requested by another physician or health care professional. An individual consulting provider should only submit one initial inpatient consultation per admission.

Reimbursement

Initial Inpatient Consultations

Inpatient consultations are represented by CPT codes 99251-99255. Oscar will reimburse only one inpatient consultation per facility admission for the same patient when submitted by the same provider.

Subsequent Inpatient Consultations

If the consulting provider assumes responsibility for the patient's care and performs subsequent services beyond the initial consultation, s/he should use the applicable evaluation and management service codes. If the consulting provider needs to perform follow-up services related to completion of the initial consultation, s/he should use the applicable subsequent care codes. CPT codes 99251-99255 will not be reimbursed for subsequent services performed by the consulting provider.

Publication History

Date	Action/Description
12/09/2015	Original Documentation
[xx/xx/2015]	**[Approval and inclusion in Oscar Provider Manual]**

Readmissions

Policy:

For all inpatient stays, Oscar reserves the right to review readmissions for the same or related conditions within 30 days of discharge.

30-Day Readmissions

This payment policy provides guidance in line with CMS guidelines for 30-day readmissions.
This policy addresses the reimbursement of readmissions to the same hospital system billed on a UB-04 claim form.

The policy is intended to provide general guidance and is not intended to address every situation. Oscar reserves the right to interpret and apply it to the reimbursement of services provided. The provider is responsible for submitting accurate claims.

Overview
The Hospital Readmissions Reduction Program (HRRP) and the Centers for Medicare and Medicaid Services (CMS) implemented a program that encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans, and as a result, reduce avoidable member readmissions. Following the guidelines stipulated, Oscar has implemented a process for reviewing readmissions to the same hospital or hospital system within 30 days.

Definitions
"Readmission" is defined as a hospitalization in an acute care hospital following a prior admission to the same hospital or health system within 30 days.

"Preventable" is a term used to define whether a particular readmission could have been avoided or prevented, such as by one of the following interventions:

- Appropriate quality of care during the prior admission (e.g., better management of patient disease and comorbidities)
- Appropriate discharge planning and post-discharge follow-up (e.g., arranging primary care or specialist follow-up, ensuring patient medication understanding, etc.)

"Diagnosis-Related Group (DRG)" is a classification system for hospital admission. It allows providers/hospitals to bill a specific DRG code as classified by organ systems and then the specific subgroup. Codes are also classified as surgical or medical.

"Major Diagnostic Category (MDC)" is a classification system that is implemented alongside the DRG system. It is formed by further dividing all possible principal diagnoses from the International Statistical Classification of Diseases into 25 mutually exclusive diagnosis areas.

Readmissions Policy Criteria

Oscar flags readmissions that fall in the below criteria:

The readmission occurred within the specified time interval, as defined as one of the following, and:

a. Within 30 days of the initial discharge; or
b. Within 30 days of a prior preventable readmission meeting the below criteria
    i. The readmission occurred within the same inpatient hospital or health system; and
    ii. The readmission is the same MDC and same DRG as the initial admission, implying the member is readmitted for reasons clinically related to the initial admission; or
c. Within 30 days of a prior preventable readmission meeting the below criteria
    i. The readmission occurred within the same inpatient hospital or health system; and
    ii. The readmission is the same MDC as the initial admission, implying the member is readmitted for reasons clinically related to the initial admission

Readmissions Policy Reimbursement Guidelines

1. If readmission is of the same MDC and DRG as the initial admission, the payments will be bundled. We will not reimburse another DRG for members who are readmitted to the same facility for symptoms related to the prior stay's medical condition within 30 calendar days.

2. If readmission is of the same MDC as the initial admission, the payments will be bundle and the larger paying DRG will be reimbursed
    a. Ex. If the first DRG is a larger amount, we will not reimburse the second claim. If the second claim is larger, we will pay the difference in what was already paid in the first claim and second claim to equal the second claim's DRG payment.

Exclusion Criteria

Oscar may consider a readmission unavoidable and eligible for reimbursement when one of the following criteria is met:

1. Planned Readmissions, as specified in patient discharge status; or
2. Patient-initiated discharge "against medical advice" (AMA), as specified in patient discharge status; or
3. MDC codes that result in frequent member readmissions (Ex. MDC 17; Myeloproliferative Disorders or Poorly Differentiated Neoplasms); or
4. Contractual exclusions, if applicable

Publication History

Date	Action/Description
12/09/2015	Original Documentation
6/16/2016	Approval and inclusion in Oscar Provider Manual
4/18/2017	Policy updated
12/22/2020	Policy updated

Evaluation and Management Services

Policy

Oscar incorporates standards established by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) for our evaluation and management (E&M) services reimbursement policy. All services should be coded to the appropriate level of care, as laid out in the CMS and AMA guidelines, and should be able to be substantiated by medical records.

Reimbursement Guidelines

Modifiers

Code modifiers used for E&M services billing should be appropriate for the services rendered and **should** be able to be supported by medical records. Oscar may request medical records to ensure that included modifiers adhere to the standards outlined by the CMS and AMA.

Multiple Visits Per Day

Oscar will reimburse one visit per billing group, per subspecialty, per day. If both preventive and problem-oriented services are billed, and the problem-oriented visit is billed with modifier 25, Oscar will reimburse the higher-valued procedure at 100% of the otherwise allowable amount and the lower-valued procedure at 50% of the contracted rate. Minor problem-oriented visits and problem-oriented codes billed without modifier 25 will not be reimbursed. Other E&M Services will be paid at 100% when billed with modifier 25, unless addressed below.

Screening/Counseling/Nutrition Therapy/Prolonged Services/Overlapping E&M Services

If a screening, counseling, nutrition therapy, prolonged, or otherwise overlapping E&M service is coded with modifier 25 and billed on the same day as a preventive E&M service as defined in the coding section below, Oscar will reimburse 50% of the otherwise allowable amount for the non-preventative service. Otherwise, these services are not separately payable when billed on the same day as preventive E&M services by the same provider.

Examples of and exceptions to this policy are listed in the coding section below.

Bundled Services

The following services are not separately payable when billed on the same day as specific E&M services.

- Annual wellness visits are bundled into preventative visits
- Cervical or vaginal cytopathology is bundled into preventive or problem-oriented visits
- Collection of blood from an Implantable venous access device or venous catheter is bundled into problem-oriented visits
- Screening pap smears are bundled into preventative visits
- Screening pelvic/breast/rectal examinations are bundled into preventive and problem-oriented visits
- Interpretation and report of ECG is bundled into problem-oriented, inpatient, or ED visits
- Interpretation and report of cardiovascular stress tests are bundled into ED visits

- Interpretation of chest X-rays are bundled into ED and inpatient visits
- Preventive medicine counseling is bundled into preventative visits
- Removal of impacted earwax is bundled into any E&M visit
- Pulse oximetry is bundled into any E&M visit

Services During Global Periods

E&M services are not separately payable when provided on the same day (or the day prior, for major surgical procedures) as a procedure with a global period, as defined by the CMS or Oscar (for codes with global surgery indicator YYY). Exceptions to this policy are for significant and separately identifiable services performed on the same day as the global procedure, when billed with modifier 25, or for services resulting in a decision to perform a major surgery, when billed with modifier 57. For services billed with modifier 25, the lesser of the procedure or E&M rate is paid at 50% of the contracted rate.

E&M services provided within the global period, during the postoperative period, are not considered separately payable unless unrelated to the original procedure and billed with modifier 24.

Emergency Department (ED) Facility E&M Coding

Facilities are entitled to submit CPT E&M codes on a UB form in addition to the E&M's submitted by the ED physician. Facility resource consumption drives the eligible E&M level submitted whereas physician resources drive the physician ED E&M level as outlined by CPT. An E&M visit level evaluation tool that accounts for diagnoses submitted as well as facility services ordered and performed determines the likely appropriate level of the facility E&M reimbursement. Given the inherent variability and complexity relating to the higher level E&M codes (99283, 99284, or 99285) the evaluation tool will verify whether the higher level codes are accurately reflecting the complexity of the visit and if not, the ED E&M reimbursement will reflect the tool output. Since the focus is on purely the level 3,4 and 5 codes, coding recommendations will only focus on a reduction in code levels. This will result in:

1. Fair and appropriate facility reimbursement for ED services rendered
2. Reduction in facility up coding and corresponding overpayment

CMS indicates facilities should bill appropriately and differentially for outpatient visits, including emergency department visits. To that end, CMS coding principles applicable to emergency department services provide that facility coding guidelines should: follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code; be based on hospital facility resources and not based on physician resources; and not facilitate upcoding or gaming.

Consultation Codes

Oscar will reimburse outpatient consultation E&M codes at the equivalent problem-oriented E&M visit rate, inpatient consultations at the equivalent inpatient visit E&M code, and emergency department consultations will be reimbursed at the equivalent Emergency department E&M code. For inpatient visits, the admitting physician must submit the visit with modifier 'AI' in order for the consulting physician to be reimbursed.

Non-Reimbursable Services

Oscar does not reimburse the following services: Transitional care management, advance care planning, chronic care management services, or prolonged services provided in an inpatient setting or by clinical staff.

Coding

Categories identified above include, but are not limited to, the below codes.

Code	Description
99381-99387,99391-99397, G0402	Preventive E&M Services
99201-99205,99211-99215	Problem-Oriented E&M Services
99281-99285	Emergency Department E&M Services
99224-99226	Observation E&M Services
99221-99223,99231-99236	Inpatient E&M Services
G0438, G0439	Annual Wellness Visits
88141-88155, 88164-88167, 88174-88175	Cervical or Vaginal Cytopathology
36591, 36592	Collection of Blood from an Implantable Venous Access Device or Venous Catheter
Q0091	Screening Pap Smear
G0101	Screening Pelvic and Clinical Breast Examination
G0102	Screening Rectal Exam
93010, 93042	Interpretation and Report of ECG
93018	Interpretation and Report of Cardiovascular Stress Test
71045, 71046	Interpretation of Chest X-ray
99401-99404, 99411, 99412	Preventive Medicine Counseling
69209, 69210	Removal of Impacted Earwax
94760-94672	Pulse Oximetry
99172, 99173, 99408, 99409, G0396, G0397, G0442, G0444	Screening Services
99406, 99407, 99411, 99412, G0245, G0246, G0296, G0443, G0445-G0447, G0473, H0005, S0257, S0265, T1006, T1027	Counseling Services
G0270, G0271, S9470	Nutrition Therapy Services
99354, 99355	Prolonged Services provided by a Physician in Outpatient Setting

99241-99245, 99251-99255, 99281-99285, G0245, G0246, S0285	E&M Services overlapping with Preventative Services
99241-99245	Outpatient Consultation E&M Services
99251-99255	Inpatient Consultation E&M Services
99495, 99496	Transitional Care Management
99497, 99498	Advance Care Planning
99415, 99416	Prolonged Services provided by Clinical Staff
99356, 99357	Prolonged Services provided in Inpatient Setting
99487-99490	Chronic Care Management

Publication History

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4/02/2017	Original Documentation
4/20/2017	Approval and inclusion in Oscar Provider Manual
7/20/2017	Policy Updated
8/29/2018	Policy Updated
4/09/2019	Policy Updated
3/26/2020	Policy Updated
6/10/2020	Policy Updated

Services Delivered via Telemedicine

Policy

Oscar reimburses providers for medically necessary, covered services delivered via telemedicine or telehealth subject to federal and state regulatory restrictions.

This policy describes reimbursement for services delivered via telemedicine or telehealth, which occur when the physician or other qualified health care professional and the patient are not at the same site. Examples of such services are those that are delivered over the Internet or using other communication devices.

Definitions

See applicable state law for applicable definitions related to provision of services via telehealth or telemedicine.

Reimbursement Guidelines

Oscar reimburses services offered via telehealth or telemedicine in accordance with applicable state law and the Member's Evidence of Coverage (Policy).

Providers shall be:

- Validly licensed, certified, or registered to provide such services as required by applicable state law;
- Subject to regulation by the appropriate State licensing board or professional regulatory entity;
- In compliance with existing requirements requiring the maintenance of liability insurance; and,
- In compliance with applicable data security, patient confidentiality, and privacy regulations . A secured electronic channel is required to be utilized by a telemedicine provider. All transactions and data communication must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

For all lines of business, Oscar will consider for reimbursement Telehealth services which are recognized by the Centers for Medicare and Medicaid Services (CMS) and appended with modifiers GT or GQ, as well as services appended with modifier 95.

Oscar requires one of the following modifiers to be reported when performing a service via Telehealth to indicate the type of technology used and to identify the service as Telehealth. Oscar will consider reimbursement for a procedure code/modifier combination using these modifiers only when the modifier has been used appropriately.

Please see below for examples of referenced codes:

Coding Definitions

POS	Description
02	Telemedicine

Modifier	Description
GT	Services offered via Interactive Audio and Video Telecommunications systems.
GQ	Services offered via Asynchronous Telecommunications systems
95	Services offered via Synchronous interactive audio and video telecommunications systems

Categories of services that may be covered when provided telehealth or telemedicine include, but are not limited to, the below codes.

Code	Description
99201	Problem focused exam and history and straightforward MDM.
99202	Expanded exam and history and straightforward MDM.
99203	Detailed exam and history and low MDM.
99204	Comprehensive exam and history and moderate MDM.
99205	Complex exam and history and high MDM.
99211	Problem focused exam and history and straightforward MDM.
99212	Expanded exam and history and straightforward MDM.
99213	Detailed exam and history and low MDM.

99214	Comprehensive exam and history and moderate MDM.
99215	Complex exam and history and high MDM.
99441	Telephone evaluation and management service by a physician or other qualified healthcare professional, 5-10 minutes of medical discussion
99442	Telephone evaluation and management service by a physician or other qualified health care professional, 11-20 minutes of medical discussion
99443	Telephone evaluation and management service by a physician or other qualified health care professional, 21-30 minutes of medical discussion
99421	Online digital evaluation and management service for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99422	Online digital evaluation and management service for up to 7 days, cumulative time during the 7 days; 11-20 minutes
99423	Online digital evaluation and management service for up to 7 days, cumulative time during the 7 days; 21 or more minutes

*MDM=Medical Decision Making

Publication History

Date	Action/Description
8/20/2019	Approval and inclusion in Oscar Provider Manual
9/29/2020	Revised to include new codes

Oscar Reimbursement Policies

In-Office Laboratory Testing and Procedures

Policy

The In-Office Laboratory Testing and Procedures List is a list of laboratory procedural/testing codes that Oscar will reimburse its Network physicians to perform in their offices. This list represents procedures/tests that Oscar Network physicians can perform in their offices that will be reimbursed by Oscar at a rate similar to the CMS reimbursement for claims. All other lab procedures/tests must be performed by one of the participating laboratories in Oscar's network or reimbursement to the physician's office is reduced to a level near the contractual allowable paid to our contracted laboratories.

In-Office Laboratory Testing and Procedures Code List

Code	Description	Notes
81000	Urinalysis, non-automated, with microscopy	
81001	Urinalysis, automated, with microscopy	
81002	Urinalysis, non-automated, without microscopy	
81003	Urinalysis, automated, without microscopy	
81025	Urine pregnancy test, by visual color comparison methods	
82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided three cards or single triple card for consecutive collection)	
82271	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; other sources	
82272	Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening	
82948	Glucose; blood, reagent strip	
82962	Glucose, blood sugar by glucometer	
83014	Helicobacter pylori, breath test analysis; drug administration	
83026	Hemoglobin; by copper sulfate method, non-automated	
83655	Lead	
85013	Blood count; spun microhematocrit	
85018	Blood count; hemoglobin (Hgb)	
85651	Sedimentation rate, erythrocyte; non-automated	
86403	Particle agglutination, screen, each antibody	
86485 - 86580	Skin tests; various	
87070	Culture, bacterial; any other source but urine, blood or stool, with isolation and presumptive identification of isolates.	
87081	Culture, bacterial, screening only, for single organisms	
87177	Ova and parasites, direct smears, concentration and identification.	

87210	Smear, wet mount with simple stain, for bacteria, fungi, ova, and/or parasites	
87220	Tissue examination for fungi (e.g., KOH slide)	
87804	Infectious agent antigen detection by immunoassay with direct optical observation; Influenza	
87880	Infectious agent detection by immunoassay-streptococcus group A	
88738	Hemoglobin (Hgb), quantitative, transcutaneous	
89100	Duodenal intubation and aspiration; single specimen plus appropriate test	
89105	Duodenal intubation and aspiration; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube	
89130 - 89141	Gastric intubation and aspiration; various	
89350	Sputum, obtaining specimen, aerosol-induced technique	
99195	Phlebotomy, therapeutic (separate procedure)	
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	For Stat Purposes Only
82247	Bilirubin, Total	Pediatricians
88331	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen	Dermatologists
88332	Pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)	Dermatologists
89060	Crystal Identification by light microscopy with or without polarizing lens analysis; tissue or any body fluid (except urine)	
89300	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)	
89310	Semen analysis; motility and count (not including Huhner test)	
89320	Semen analysis; volume, count, motility and differential	
89321	Semen analysis; sperm presence and motility of sperm, if performed morphologic criteria (eg, Kruger)	
89322	Semen analysis; volume, count, motility, and differential using strict	
82803	Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation)	
85007	Blood count; automated differential WBC count blood smear, microscopic examination with manual differential WBC count	
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	
85097	Bone marrow; smear interpretation only, with or without differential cell count	
86077	Blood bank physician services; difficult cross-match and/or evaluation of irregular antibody(s), interpretation and written report	
86078	Blood bank physician services; investigation of transfusion reaction, including suspicion of transmissible disease, interpretation and written report	
86079	Blood bank physician services; authorization for deviation from standard blood banking procedures, with written report	
86927 - 86999	Transfusion medicine	
84146	Prolactin	
84443	Thyroid stimulating hormone (TSH)	
89322	Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)	
83861	Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity	Ophthalmologists

88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistological study to determine adequacy for diagnosis, first evaluation episode, each site	Endocrinologists
88177	Cytopathology, evaluation of fine needle aspirate; immediate cytohistological study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)	Endocrinologists

Publication History

Date	Action/Description
9/01/2015	Original Documentation
9/27/2015	Approval and inclusion in Oscar Provider Manual

Obstetrical Care Bundling

Policy

Maternity care includes antepartum care, delivery services, and postpartum care. This policy describes reimbursement for global obstetrical (OB) codes and itemization of maternity care services. In addition, the policy indicates what services are and are not separately reimbursable to other maternity services. Unless otherwise specified, for the purposes of this policy Same Group Physician and/or Other Health Care Professional includes all physicians and/or other healthcare professionals of the same group reporting the same federal tax identification number.

1) Global Obstetrical Care - Global Obstetrical Care As defined by the American Medical Association (AMA), "the total obstetric package includes the provision of antepartum care, delivery, and postpartum care." When the Same Group Physician and/or Other Health Care Professional provides all components of the OB package, report the global OB package code.

2) Antepartum Care Only - Accommodates for situations such as termination of a pregnancy, relocation of a patient or change to another physician. In these situations, all the routine antepartum care (usually 13 visits) or global (OB) care may not be provided by Same Group Physician and/or Other Health Care Professional.

3) Delivery Services Only - Includes admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery.

4) Postpartum Care Only - Includes the postpartum period to be six weeks following the date of the cesarean or vaginal delivery.

5) Delivery + Postpartum Care - Sometimes a physician performs the delivery and postpartum care with minimal or no antepartum care. In these instances, the CPT book has codes for vaginal and cesarean section deliveries that encompass both of these services. The following are CPT defined delivery plus postpartum care codes:

Obstetric Care Bundles

Code(s)	Description	Code Type
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	Global Obstetric
59510	Routine obstetric care including antepartum care, cesarean delivery and postpartum care	Global Obstetric
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	Global Obstetric
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.	Global Obstetric
59425	Antepartum care only; 4-6 visits	Antepartum Care Only
59426	Antepartum care only; 7 or more visits	Antepartum Care Only

59409	Vaginal delivery only (with or without episiotomy and/or forceps)	Delivery Services Only
59514	Cesarean delivery only	Delivery Services Only
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)	Delivery Services Only
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery	Delivery Services Only
59430	Postpartum care only (separate procedure)	Post-Partum Care Only
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	Delivery + Post-Partum
59515	Cesarean delivery only; including postpartum care	Delivery + Post-Partum
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	Delivery + Post-Partum
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care.	Delivery + Post-Partum

Services Included in the "Global Obstetrical" Care Package

Description	Code(s)
All routine prenatal visits until delivery (approximately 13 for uncomplicated cases)	
Initial and subsequent history and physical exams	
Recording of weight, blood pressures and fetal heart tones	
Routine chemical urinalysis	81000, 81002
Admission to the hospital including history and physical	
Inpatient Evaluation and Management (E/M) service provided within 24 hours of delivery	
Management of uncomplicated labor	
Delivery of placenta	59414
Administration/induction of intravenous oxytocin	96365 - 96367
Insertion of cervical dilator on same date as delivery	59200
Repair of first or second degree lacerations	
Simple removal of cerclage (not under anesthesia)	
Uncomplicated inpatient visits following delivery	
Routine outpatient E/M services provided within 6 weeks of delivery	

Services Excluded from the "Global Obstetrical" Care Package

The following services are excluded from the global OB package and may be reported separately if warranted:

Description	Code(s)
Initial E/M to diagnose pregnancy if antepartum record is not initiated at this confirmatory visit. This confirmatory visit would be supported in conjunction with the use of diagnosis code V72.42 (Pregnancy examination or test, positive result)	
Laboratory tests (excluding routine chemical urinalysis)	
Maternal or fetal echography procedures	76801 - 76828
Amniocentesis, any method	59000, 59001
Amnioinfusion	59070
Chorionic villus sampling (CVS)	59015
Fetal contraction stress test	59020

Fetal non-stress test	59025
External cephalic version	59412
Insertion of cervical dilator more than 24 hours before delivery	59200
E/M services for management of conditions unrelated to the pregnancy (e.g., bronchitis, asthma, urinary tract infection) during antepartum or postpartum care; the diagnosis should support these services.	
Additional E/M visits for complications or high risk monitoring resulting in greater than the typical 13 antepartum visits; per ACOG these E/M services should not be reported until after the patient delivers. Append modifier 25 to identify these visits as separately identifiable from routine antepartum visits.	
Inpatient E/M services provided more than 24 hours before delivery	
Management of surgical problems arising during pregnancy (e.g., appendicitis, ruptured uterus, cholecystectomy).	

Services Included in the "Delivery Services Only" Care Package

Description	Code(s)
Admission to the hospital	
The admission history and physical examination	
Management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps, with or without vacuum extraction), or cesarean delivery, external and internal fetal monitoring provided by the attending physician	
Intravenous (IV) induction of labor via oxytocin	96365 - 96367
Delivery of the placenta; any method	
Repair of first or second degree lacerations	
Cervical dilator	59200

High Risk/Complications

A patient may be seen more than the typical 13 antepartum visits due to high risk or complications of pregnancy. These visits are not considered routine and can be reported in addition to the global obstetrical codes. The submission of these high risk or complication services is to occur at the time of delivery, because it is not until then that appropriate assessment for the number of antepartum visits can be made. Oscar will separately reimburse for E/M services associated with high risk and/or complications when modifier 25 is appended to indicate it is significant and separate from the routine antepartum care and the claim is submitted with an appropriate high risk or complicated diagnosis code.

E/M Service with an Obstetrical (OB) Ultrasound Procedure

Oscar follows ACOG coding guidelines and considers an E/M service to be separately reimbursed in addition to an OB ultrasound procedures (CPT codes 76801-76817 and 76820- 76828) only if the E/M service has modifier 25 appended to the E/M code. If the patient is having an OB ultrasound and an E/M visit on the same date of service, by the Same Individual Physician or Other Health Care Professional, per ACOG coding guidelines the E/M service may be reported in addition to the OB ultrasound if the visit is identified as distinct and separate from the ultrasound procedure. Per CPT guidelines, modifier 25 should be appended to the E/M service to identify the service as separate and distinct.

Multiple Gestation

Oscar's reimbursement for twin deliveries follows ACOG's coding guidelines for vaginal, cesarean section, or a combination of vaginal and cesarean section deliveries. See table below for appropriate code submission regarding delivery of twin births.

Delivery Type	Baby	Code-Modifier
Vaginal	Baby A	59400
	Baby B	59409-59
VBAC	Baby A	59610
	Baby B	59612-59
Cesarean Delivery	Baby A + Baby B	59510
Repeat Cesarean Delivery	Baby A + Baby B	59518
Vaginal Delivery + Cesarean Delivery	Baby A	59409-51
	Baby B	59510
VBAC + repeat Cesarean Delivery	Baby A	59612-51
	Baby B	59618

Publication History

Date	Action/Description
9/01/2015	Original Documentation
9/27/2015	Approval and inclusion in Oscar Provider Manual

Assistant Surgeon

Policy

An assistant surgeon is considered medically necessary when the complexity of the operation necessitates the primary surgeon have additional skilled operative assistance from: 1) Another surgeon, 2) Licensed Physician Assistant, 3) Registered Nurse First Assistant. Oscar provides coverage for assistant surgeons based on guidance from the Centers for Medicare and Medicaid Services (CMS).

An assistant surgeon is distinguished from an “assistant-in-surgery.” Generally, assistants-in-surgery are non-MD professionals such as nurses, operating room technicians, or other specially trained professionals, whose services are included in the primary surgeon’s, or the facility’s, reimbursement. These services are not separately reimbursed.

There may be times when a physician elects to utilize more than one assistant during the operative session. However, only one assistant per operative session will be reimbursed. Claims for services of an assistant surgeon should be filed with modifier 80, 81, 82 or AS. Use of modifiers is required for proper payment.

Coding

Oscar follows criteria based on the CMS National Physician Fee Schedule Relative Value File (NPFS) status indicators. All codes in the NPFS with the status code indicator "2" for "Assistant Surgeons" are considered by Oscar to be reimbursable for Assistant Surgeon services, as indicated by an Assistant Surgeon modifier (80, 81, 82, or AS).

Assistant Surgeons who are Physicians or non-Physicians should submit the identical procedure code(s) as the primary surgeon with one of the following modifiers to represent their service(s):

Assistant Surgeon Modifiers

Modifier	Description	Type of Professional
80	Assistant Surgeon	Physician
81	Minimum Assistant Surgeon	Physician
82	Assistant Surgeon (when qualified resident surgeon not available)	Physician
AS	PA (physician assistant), nurse practitioner, or clinical nurse specialist services for assistant at surgery	non-Physician*

* Health care professionals acting as Assistant Surgeons should report their services under a surgeon's provider number.

Reimbursement

Oscar's standard reimbursement for qualified Assistant Surgeon services are 16% of the primary surgeon's allowable amount when performed by a physician and 14% of the primary surgeon's allowable amount when performed by a non-Physician (as defined above). This percentage is based on CMS.

Publication History

Date	Action/Description
9/01/2015	Original Documentation
10/05/2015	Initial Policy Approval
4/20/2017	Policy Updated

Co-Surgeons / Team Surgeons

Policy

The use of multiple surgeons for a single procedure is considered medically necessary when the nature and/or complexity of the procedure necessitates contribution and expertise from more than one surgeon. Oscar provides coverage for multiple surgeons based on guidance from the Centers for Medicare and Medicaid Services (CMS).

Coding

Oscar follows criteria based on the CMS National Physician Fee Schedule Relative Value File (NPFS) status indicators. All codes in the NPFS with status code indicators "1" or "2" for "Co-Surgeons" are considered by Oscar to be eligible for Co-Surgeon services as indicated by the co-surgeon modifier 62. All codes in the NPFS with the status code indicators "1" or "2" for "Team Surgeons" are considered by Oscar to be eligible for Team Surgeon services as indicated by the team surgeon modifier 66. Use of modifiers is required for proper payment.

Co-Surgeon & Team Surgeon Modifiers

Modifier	Description	Type of Professional
62	Two Surgeons	Physician *
66	Team Surgeons	Physician

* Physicians acting in the more limited capacity of an 'Assistant Surgeon' should bill with modifiers 80 or 82 and are not eligible for Co-Surgeon reimbursement

Reimbursement

Co-Surgeons

Each co-surgeon should submit the same Current Procedural Terminology (CPT) code with modifier 62. Consistent with CMS guidelines, Oscar will reimburse co-surgeon services at 62.5% of the allowable amount to each surgeon subject to additional multiple procedure reductions if applicable. The allowable amount is determined independently for each surgeon and is the amount that would be given to that surgeon performing the surgery without a co-surgeon.

Team Surgeons

Each Team Surgeon should submit the same CPT code with modifier 66 along with written medical documentation describing the specific surgeon's involvement in the total procedure. Oscar will review each submission with its appropriate medical documentation and will make reimbursement decisions on a case-by-case basis.

Publication History

Date	Action/Description

9/01/2015	Original Documentation
10/05/2015	Initial Policy Approval

Non-Reimbursable Services

Policy

Oscar does not reimburse for the procedures or categories of codes outlined in this policy. This list is not all-inclusive. Denials include non-covered services defined as exclusions in the member's evidence of coverage (EOC), payment included in the allowance of another service (i.e., global) and procedure codes submitted that are not eligible for payment.

Coding

Category II CPT Codes (XXXXF)
These codes are intended to facilitate data collection about quality of care. Use of these codes is optional, not required for correct coding, and may not be used as a substitute for Category I codes.

Category III CPT Codes (XXXXT)
Temporary codes for emerging technology, services and procedures. Services should be resubmitted with an unlisted code. Supporting documentation is required with the claim.

Non-Professional Component Codes with Professional Modifier
Oscar does not reimburse codes identified by CMS as having no professional component (PC/TC Indicator of 3,4, or 9) when billed with a -26 modifier.

Separate Technical Component Services at Facility Place of Service
Oscar does not reimburse technical component services billed separately from the facility claim when performed in a facility place of service.

PC/TC Indicator 5 Codes
Oscar denies "Incident To" codes identified with a CMS PC/TC indicator 5 in the NPFS when reported in a facility place of service when billed by a physician. Modifiers -26 and TC cannot be used with these codes.

Measurement and Reporting Codes
Oscar will not reimburse measurement codes (codes with RVU status indicator of 'M' or listed below as a measurement and reporting code).

Private Payer Codes (SXXXX)
Oscar's standard policy is to not reimburse private payer codes.

OPPS Codes (CXXXX)
Oscar's standard policy is to not reimburse OPPS codes when billed on a HCFA-1500 form.

Miscellaneous Non-Reimbursable Codes
Oscar does not reimburse the below codes when billed on a HCFA-1500 form.

Obsolete and Unreliable Tests and Procedures
Oscar does not reimburse obsolete and unreliable tests and procedures that are outdated and no longer the standard of care.

Coding
Categories identified above include, but are not limited to, the below codes.

Code	Description
76376, 76377	3D Radiographic Procedures
84112	Placental Protein Test
99026,99027	Hospital Mandated On-Call Service
99360	Prolonged Standby Service
99378	Physician Supervision of Hospice Services
A4216, A4218	Sterile Water, Saline and/or Dextrose
A4264	Permanent Implantable Contraceptive Intratubal Occlusion Device(s) and Delivery System
A4470	Gravlee Jet Washer
A4480	Vabra Aspirator
A4649	Surgical Supply; Miscellaneous
A4650	Implantable Radiation Dosimeter, each
A9279	Monitoring Feature/Device
A9901	DME Delivery, Set Up, and/or Dispensing Service
G0276	Blinded Procedure for Lumbar Stenosis

G0390	Trauma Response Team associated with Hospital Critical Care Service
G0452	Molecular Pathology Procedure
G0459	Inpatient Telehealth Pharmacologic Management
G0466-G0470	FQHC Visit Codes
G0473	Face-to-Face Behavioral Counseling for Obesity
G3595-G9999	Measurement and Reporting Codes
H0048, P9603,P9604	Specimen Handling
J1642	Heparin Lock Flush
Q0511, Q0512	Pharmacy Supply Fee
30210, 38530, 43754, 43755, 51020, 51030, 51605, 52250, 55705, 55720, 55725, 82024, 82150, 82495, 82930, 82965, 85345, 85347, 85348, 86185, P2028, P2029, P2033, P2038	Obsolete or Unreliable Tests and Procedures

Place of Service Code	Description
19, 21, 22, 23, 24, 26, 34, 51, 52, 56, 61	Facility Place of Service

Publication History

Date	Action/Description
9/01/2015	Original Documentation
10/05/2015	Approval and inclusion in Oscar Provider Manual
4/20/2017	Policy Updated
8/29/2018	Policy Updated

Anesthesia

Policy

Oscar Insurance reimburses anesthesia based on the concepts of basic values, time unit values, and conversion factors. Basic values are defined by the ASA and time units are calculated on a 15 minute interval basis and rounded to the nearest decimal point (e.g. 32 minutes of anesthesia equals 2.1 time units). Conversion factors are either explicitly listed in provider contracts or based on CMS localities. Anesthesia time starts when the anesthesiologist begins to prepare the patient for induction and ends when the patient can safely be placed under postoperative supervision.

The following formula is used to determine anesthesia reimbursement:

(Base Value + Time Units) x Conversion Factor = Reimbursement

The following modifiers should also be applied to distinguish when services are not directly performed by an anesthesiologist:

Type of Provider	Code	Description	Payment
Anesthesiologist	AA	Anesthesia services performed personally by an anesthesiologist	100% of fee schedule based on appropriate unit rate
	AD	Medical supervision for more than four concurrent anesthesia procedures is provided	Reimbursed at a rate equal to three base value units
	GC	Services performed in part by a resident under the direction of a teaching physician	Services are reimbursable at 100% of the allowable when billed by the teaching anesthesiologist. (Note: the teaching anesthesiologist must bill with the “AA” modifier in the first field and the “GC” certification modifier in the second field.)
	QK	Medical direction of two, three or four concurrent anesthetic procedures involving qualified individuals (e.g., CRNAs or residents)	Allows 50% of fee schedule payment based on the appropriate unit rate
	QY	Anesthesiologist medically directed one CRNA	Allows 50% of fee schedule payment based on the appropriate unit rate
CRNA	QZ	CRNA performed services without medical direction	100% of fee schedule based on appropriate unit rate
	QX	CRNA performed services under the medical direction of an anesthesiologist	Allows 50% of fee schedule payment based on the appropriate unit rate

There are also a few additional cases that require more specific pricing. These include:

- Reimbursement for neuraxial/epidural labor is based on the actual time unit capped at the following minutes:

- Vaginal delivery codes are capped at a total of 225 minutes/15 time units
- Cesarean section delivery codes are capped at a total of 270 minutes/18 time units

Publication History

Date	Action/Description
09/01/2015	Original Documentation
10/05/2015	Approval and inclusion in Oscar Provider Manual
03/07/2016	Policy Updated
07/20/2017	Policy Updated

Hospital Based Clinics

Policy

Oscar reimburses professional providers for covered services provided in a facility clinic setting when reported on a professional CMS 1500 form with a place of service office. This reimbursement includes both the professional services and the associated overhead. Oscar will not separately reimburse a facility for facility clinic visits and services billed on a UB-04 when reported with revenue codes 510-519, 520-529 and any successor codes.

The technical and overhead component of the facility clinic visit is included in the benefit paid to the professional provider for professional services, which encompasses but is not limited to E&M services in a clinic setting. The facility may not seek reimbursement for any technical or overhead component of the clinic charge from Oscar or the member. The member is held harmless for these clinic overhead charges.

Coding

Codes	Description	Comment
510 - 519	Clinics	Bill with appropriate CPT/HCPCS codes; E&M codes will be denied.
520 - 529	Free Standing Clinics	Bill with appropriate CPT/HCPCS codes; E&M codes will be denied.
960-969	Professional Fees - Clinics	Bill with appropriate E&M codes
G0463	Hospital Outpatient clinic visit for assessment and management of a patient	Not reimbursed

Publication History

Date	Action/Description
11/11/2015	Original Documentation
12/01/2015	Approval and inclusion in Oscar Provider Manual

Bilateral Procedures

Policy

Bilateral procedures are procedures performed on both sides of the body during the same encounter or on the same day. Oscar follows the bilateral procedure CMS standards in the NPFS (National Physician Fee Schedule) for adjustment of payment.

Bilateral services must be billed on a single line with modifier -50 appended. Modifier -50 is not applicable to procedures that are bilateral by definition or procedures with descriptions that include such terminology as "bilateral" or "unilateral." Do not use Modifiers RT and LT when modifier -50 applies.

Reimbursement

Procedure Eligible for Bilateral Payment Adjustment

Status Indicator 1:
If the procedure is billed with the -50 bilateral modifier, a 150% payment adjustment applies.

Status Indicator 3:
Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures with CMS status indicator 1. If a procedure is reported with modifier -50, payment is based on 100% of the standard reimbursement for each side.

Procedures Ineligible for Bilateral Payment Adjustment

Status Indicator 2:
Payment for these services is already considered bilateral. If the procedure is submitted with modifier -50 or reported twice, payment is still 100% of the standard reimbursement.

Publication History

Date	Action/Description
10/09/2015	Original Documentation
11/01/2015	Initial Policy Approval

Multiple Procedures

Policy

When multiple procedures are performed on the same day, by the same group, physician, or other healthcare professional, reduction in reimbursement for secondary and subsequent procedures will occur. Oscar follows the multiple procedure CMS standards for reduction of payment. The use of modifier 51 appended to a code is not a factor in determining which codes are considered subject to multiple procedure reductions.

Reimbursement

Surgical / Endoscopic Procedures (Status Indicators 2 & 3)
If a procedure is reported on the same day as another procedure with an indicator of 2 or 3, the procedures with the greatest reimbursable amount will be paid at 100% followed by 50% for all subsequent procedures. Payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

Special rules for multiple endoscopic procedures apply if an endoscopic procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the Endobase field of the CMS NPFS Relative Value File. The multiple endoscopy rules are applied to a family before ranking the family with the other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, the base procedure is not separately payable. Payment for the base procedure is included in the payment for the other endoscopy.

Therapy Services (Status Indicator = 5)
For therapy services, full payment is made for the service with the highest payment. Payment is reduced by 50 percent of the practice expense component for subsequent services furnished by the same physician (or by multiple physicians in the same group practice, to the same patient on the same day). Reduction is taken only on the practice expense component, the other components are paid at 100% for all procedures.

Cardiovascular Services (Status Indicator = 6)
For cardiovascular services, full payment is made for the service with the highest payment. Payment is made at 75 percent for subsequent services furnished by the same physician (or by multiple physicians in the same group practice, to the same patient on the same day). Reduction is taken only on the technical component, the professional component is paid at 100% for all procedures.

Ophthalmology Services (Status Indicator = 7)
For ophthalmology services, full payment is made for the service with the highest payment. Payment is made at 80 percent for subsequent services furnished by the same physician (or by multiple physicians in the same group practice, to the same patient on the same day). Reduction is taken only on the technical component, the professional component is paid at 100% for all procedures.

Global / Case Rate Adjustment

When a procedure requires a multiple procedure reduction but is billed as a global / case-rated procedure, Oscar will apply an appropriate technical component reduction on a fixed 60% of the total payable amount. If a professional component payment reduction is appropriate, it is applied on a fixed 40% of the total payable amount.

Sources

CMS Transmittal 995 (11/04/2011):
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R995OTN.pdf

Publication History

Date	Action/Description
09/01/2015	Original Documentation
10/01/2015	Initial Policy Approval
07/20/2017	Policy Updated
08/19/2019	Policy Updated

Unlisted and Unspecified Procedures

Policy

Unlisted procedure codes are used when the services performed do not have specific codes assigned to them. When submitting claims with such unlisted or unspecified procedures, it is necessary to attach supporting documentation describing the services that were performed. Such documentation should include the following information:

- A clear description of the nature, extent, and need for the procedure or service;
- Whether the procedure was performed independently of other services provided, or if it was performed at the same surgical site or through the same surgical opening;
- Any extenuating circumstances which may have complicated the service or procedure;
- Time, effort, and equipment necessary to provide the service; and
- The number of times the service was provided.

When submitting documentation, designate the portion of the report that identifies the test or procedure associated with the unlisted procedure code.

Reimbursement

Claims submitted with unlisted procedure codes and without supporting documentation will be denied. No additional reimbursement is provided for special techniques/equipment submitted with an unlisted procedure code. When performing two or more procedures that require the use of the same unlisted CPT code, the unlisted code should only be reported once to identify the services provided (excludes unlisted HCPCS codes; for example, DME/ unlisted drugs). Unlisted codes for DME, orthotics, and prosthetics require appropriate NU, RR or MS modifier in order to be considered for reimbursement. All other unlisted procedure codes appended with a modifier will be denied.

Required Documentation

Procedure Code Category	Documentation Requirements
Surgical procedures: all unlisted codes within the range of 10021–69990	Operative or procedure report
Radiology/imaging procedures: all unlisted codes within the range of 70010–79999	Imaging report
Laboratory and pathology procedures: all unlisted codes within the range of 80047–89398	Laboratory or pathology report
Medical procedures:	Office notes and reports

all unlisted codes within the range of 90281–99607	
Unlisted HCPCS procedure codes	Operative or procedure report
Unclassified drug codes	NDC Number with full description/name and strength of the drug
Unlisted HCPCS DME codes	Provide narrative on the claim

Publication History

Date	Action/Description
10/09/2015	Original Documentation
11/01/2015	Initial Policy Approval

Medically Unlikely, Mutually Exclusive, and Component Procedures

Policy

Oscar reimburses providers for services that are medically appropriate and adhere to CMS standard coding conventions. Oscar follows Medicare National Correct Coding Initiative (NCCI) standards for not reimbursing services that are mutually exclusive, medically unlikely, or component services reported alongside more comprehensive procedures.

Reimbursement

Mutually Exclusive Procedures

Mutually exclusive procedures are codes that cannot reasonably be done at the same anatomic site, during the same patient encounter, or the coding combination represents two methods of performing the same service. An example of mutually exclusive procedures is the repair of an organ, performed by two different methods since only one method can be chosen to repair the organ. Mutually exclusive coding combinations are considered submitted in error and only one of the services will be reimbursed. The Medicare National Correct Coding Initiative (NCCI) has published procedure-to-procedure (PTP) claims edits that prevent inappropriate payment in these scenarios. Oscar adopts these claims edits and will not reimburse providers for mutually exclusive procedures.

Medically Unlikely Procedures

Medically unlikely procedures are codes that are anatomically or clinically limited with regard to the number of times they may be performed on a single day. In addition to the PTP edits, NCCI has published medically unlikely claims edits (MUEs) that prevent payment for an inappropriate number or quantity of the same service on a given day. Oscar adopts these claims edits and will not reimburse providers for services flagged as medically unlikely.

Comprehensive and Component Procedures

NCCI's PTP edits also address component and comprehensive procedures. Services that are integral to another service are component parts of the more comprehensive procedure. The PTP edits prevent payment for component services reported alongside comprehensive services. Oscar adopts these claims edits and will not separately reimburse providers for component services if reported alongside comprehensive services.

Publication History

Date	Action/Description
10/09/2015	Original Documentation
11/01/2015	Initial Policy Approval

Services Incidental to Admission

Policy

Services rendered prior to a related inpatient admission are considered incidental to such admission and are not separately reimbursable from the inpatient reimbursement rate.

Services that are incidental to an admission include, but are not limited to:

- Surgical day care;
- Observation stay;
- Emergency room care; and
- Diagnostic and/or testing services, including pre-admission testing.

Pre-admission services may be subject to post-payment audits and retractions.

Reimbursement

Inpatient Stays Reimbursed Per Diem

Oscar includes incidental services in the inpatient per diem reimbursement rate when they occur within one day prior to an inpatient admission. For example, an observation stay that converts to an inpatient admission before midnight of the same day is included in the inpatient per diem rate and is not separately reimbursed. On the other hand, an observation stay that converts to an inpatient admission after midnight of the observation day is not included in the per diem rate and is separately reimbursed.

Inpatient Stays Reimbursed via Case Rate or Diagnosis-Related Group (DRG)

Oscar includes incidental services in the inpatient case rate or DRG reimbursement rate when they occur within three days prior to an inpatient admission.

Publication History

Date	Action/Description
12/09/2015	Original Documentation
9/30/2017	Approval and inclusion in Oscar Provider Manual

Observation Stays

Policy

An Observation Stay is an alternative to an inpatient admission that allows reasonable and necessary time to evaluate and render medically necessary services to a member whose diagnosis and treatment are not expected to exceed 24 hours but may extend further, and the need for an inpatient admission can be determined within this specific period. Oscar reimburses observation services performed in an Oscar-contracted facility only under specific circumstances.

Reimbursement

Emergency Department Services Preceding Observation Stay

- When emergency department services precede an observation stay, the emergency department services are incidental to the observation stay and therefore are not reimbursed separately.

Obstetrical Observation Stay

When an obstetrical patient is placed in observation status:

- The entire episode is considered an inpatient admission if delivery occurs prior to discharge.
- The episode is considered an observation stay if delivery does not occur and the member is sent home.
- Reimbursement includes diagnostic testing performed in conjunction with an obstetrical observation stay.

Oscar Does Not Reimburse:

Observation stay is not considered an appropriate designation for the following, and is therefore not reimbursed:

- Preparation for, or recovery from, diagnostic tests (e.g., fetal non-stress test, sleep studies)
- The routine recovery period following a surgical day care or an outpatient procedure
- Services routinely performed in the emergency department or outpatient department
- Observation care services submitted with routine pregnancy diagnoses
- Retaining a member for socioeconomic factors
- Custodial care

Publication History

Date	Action/Description
9/01/2015	Original Documentation
10/05/2015	Approval and inclusion in Oscar Provider Manual
5/05/2016	Update to Policy
8/07/2019	Update to Policy

Surgical Supplies

Policy

This policy describes the reimbursement methodology for general surgical supplies associated with outpatient physician surgical services. Consistent with CMS, Oscar does not reimburse providers for general surgical supplies.

Reimbursement

Supply Code 99070

For reimbursement of covered medical and surgical supplies, an appropriate Level II HCPCS code must be submitted. The non-specific CPT code 99070 (supplies and materials, except spectacles, provided by the physician, hospital, ambulatory surgical center or other qualified healthcare professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)) is not reimbursable in any setting.

Surgical Tray Code A4550

CPT code A4550 will not be reimbursed separately. This code is considered to be part of a physician's practice expense and thus reimbursement of this code is included in the payment of other codes billed by the physician.

Publication History

Date	Action/Description
9/01/2015	Original Documentation
10/05/2015	Approval and inclusion in Oscar Provider Manual

Dual Preventative & Problem-Oriented Visit

Policy

Preventive Medicine Services include annual physical and well child examinations, usually separate from disease-related diagnoses. Occasionally, an abnormality is encountered or a pre-existing problem is addressed during the Preventive visit, and significant elements of related Evaluation and Management (E/M) services are provided during the same visit. When this occurs, Oscar will reimburse the Preventive Medicine service plus the following problem-oriented E/M service codes when that code is appended with modifier 25. If the problem-oriented service is minor, or if the code is not submitted with modifier 25 appended, it will not be reimbursed.

When a Preventive Medicine service and other E/M services are provided during the same visit, only the Preventive Medicine service will be reimbursed.

Screening services include cervical cancer screening; pelvic and breast examination; prostate cancer screening; digital rectal examination; and obtaining, preparing and conveyance of a Papanicolaou smear to the laboratory. These screening procedures are included in (and are not separately reimbursed from) the Preventive Medicine service rendered on the same day for members age 22 years and over.

Publication History

Date	Action/Description
9/01/2015	Original Documentation
10/05/2015	Approval and inclusion in Oscar Provider Manual

Emergent Admissions

Policy

Oscar covers emergency services that are medically necessary to screen and stabilize members in a medical or behavioral health emergency. Members who believe they are having a medical or behavioral health emergency are encouraged to seek care at the nearest emergency facility. Neither a referral from the PCP nor prior authorization from Oscar are required. In compliance with the Affordable Care Act (ACA), Oscar covers out-of-network Emergency Health Services at an in-network equivalent benefit level.

An Emergent Admission is defined as an admission to the inpatient hospital level of care immediately subsequent to an Emergency Department (ED) Visit. An example of this may be a patient requiring emergency surgery (e.g. ruptured appendix, multiple trauma, etc.) who is taken to the operating room and admitted to the inpatient setting after discharge from the Recovery Room.

Medical Review:

1. A prior authorization is not required for an emergent admission.
2. All emergent admissions are subject to concurrent and retrospective review.
3. Admitting hospitals are responsible for notifying Oscar of an emergent/urgent inpatient admission **within two business days** following an emergent/urgent admission. Notification may be communicated by fax or phone to Oscar's Medical Operations Team. Phone: 855-OSCAR-55 or Fax: 844-965-9053
4. Oscar may elect to transfer the enrollee to a network facility as soon as medically appropriate. If the enrollee chooses to stay at the non-network facility after the date that it is determined a transfer is medically appropriate, non-network benefits may be applied for the remainder of the inpatient stay.
5. Emergent admissions at in-network facilities must meet the threshold of medical necessity. Emergent admissions at out-of-network facilities must meet the higher threshold of medical necessity and emergency care of sufficient acuity and severity that would not allow the member to have received equivalent care at a later date in an in-network facility

Reimbursement:

1. <u>ED visit is inclusive of inpatient stay:</u>
   If the patient is admitted to the inpatient setting for a condition that the Plan agrees is medically necessary and is subsequent to an ED Visit, the ED visit is inclusive to the inpatient stay.
2. <u>Resubmission of a denied inpatient stay:</u>
   If an admission is denied upon concurrent or retrospective review as not meeting medical necessity criteria for admission to the inpatient setting, the provider may resubmit a claim at an alternate level of care or as an outpatient ER visit to allow payment of the ED visit portion.

3. Itemized bills requested for partially denied inpatient stays:

   If an emergent admission is determined to NOT meet medical necessity criteria for a portion of the stay, Oscar will deny the claim with a request for an itemized bill to split and pay a portion of the claim.

4. Claims denied if notification not provided:

   If an emergent admission is not reviewed prior to claim submission, the claim will be denied with a request for medical records.

Publication History

Date	Action/Description
12/09/2015	Original Documentation
6/16/2016	Approval and inclusion in Oscar Provider Manual

Transfers

Policy

In cases where a patient is transferred during an inpatient stay to the home or another facility, Oscar reimburses both the transferor and the transferee, subject to reimbursement adjustments.

Reimbursement Guidelines

For inpatient stays reimbursed using a DRG base rate, Oscar reimburses the transferor the lesser of an adjusted per diem rate and the standard DRG rate. The per diem rate is calculated depending on the DRG assigned for stay for the transferring facility and the type of facility or service to which the patient is transferred. The transfer information is determined from the patient discharge status code.

Transfers to Acute Care Facilities
The adjusted per diem rate is calculated by dividing the standard rate by the geometric mean length of stay for the assigned DRG. The date of admission is counted as two days and each subsequent day counts as a single day for calculating the adjusted per diem payment. This payment is used for all DRGs where the patient is transferred to a short term general hospital for inpatient care or a Critical Access Hospital.

The receiving provider is paid at the standard rate.

Transfers to Post-Acute Care Facilities or Services
The adjusted per diem rate is calculated by dividing the standard rate by the geometric mean length of stay for the assigned DRG. The date of admission is counted as as two days and each subsequent day counts as a single day for calculating the adjusted per diem payment. This payment applies to DRGs designated by CMS as post-acute DRGs when a patient is transferred to a skilled nursing facility, home care of organized home health service organization, an inpatient rehabilitation facility, a long term care hospital, a psychiatric hospital or psychiatric distinct unit of a hospital, or another type of institution not otherwise referenced in this document for inpatient care.

Transfers to post-acute care facilities or services with an assigned DRG designated as a special pay DRG by CMS are subject to a blended transfer rate. This per diem rate is calculated using 50% of the standard DRG rate plus 50% of the adjusted per diem rate outlined above.

The receiving provider is paid at the standard rate.

Transfers from Stand-Alone Emergency Facilities
In the event a member is transferred from a stand-alone emergency facility to an inpatient admission, the payment to the stand-alone facility is subject to reimbursement adjustments. For transfers within the same system, the outpatient visit is not separately reimbursable and is considered to be included in the payment for the inpatient

admission. For transfers between unaffiliated facilities, the outpatient visit is subject to a 50% reduction in allowed amount. For the purposes of this policy, stand-alone emergency facilities are facilities that have limited or no inpatient beds, cannot provide trauma or intensive care treatment, and have limited surgical capabilities.

Coding

Categories identified above include, but are not limited to, the below codes.

Patient Discharge Status Code	Description
02	Discharged/transferred to other short term general hospital for inpatient care.
66	Discharged/transferred to a Critical Access Hospital.
03	Discharged/transferred to skilled nursing facility (SNF).
05	Discharged/transferred to another type of institution.
06	Discharged/transferred to home care of organized home health service organization.
62	Discharged/transferred to an inpatient rehabilitation facility.
63	Discharged/transferred to a long term care hospitals.
65	Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital.

Publication History

Date	Action/Description
7/21/2016	Original Documentation
7/27/2016	Approval and inclusion in Oscar Provider Manual
8/27/2018	Policy Updated

Readmissions

Policy:

For all inpatient stays, Oscar reserves the right to review readmissions for the same or related conditions within 30 days of discharge.

30-Day Readmissions

This payment policy provides guidance in line with CMS guidelines for 30-day readmissions.
This policy addresses the reimbursement of readmissions to the same hospital system billed on a UB-04 claim form.

The policy is intended to provide general guidance and is not intended to address every situation. Oscar reserves the right to interpret and apply it to the reimbursement of services provided. The provider is responsible for submitting accurate claims.

Overview
The Hospital Readmissions Reduction Program (HRRP) and the Centers for Medicare and Medicaid Services (CMS) implemented a program that encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans, and as a result, reduce avoidable member readmissions. Following the guidelines stipulated, Oscar has implemented a process for reviewing readmissions to the same hospital or hospital system within 30 days.

Definitions
“Readmission” is defined as a hospitalization in an acute care hospital following a prior admission to the same hospital or health system within 30 days.

“Preventable” is a term used to define whether a particular readmission could have been avoided or prevented, such as by one of the following interventions:

- Appropriate quality of care during the prior admission (e.g., better management of patient disease and comorbidities)
- Appropriate discharge planning and post-discharge follow-up (e.g., arranging primary care or specialist follow-up, ensuring patient medication understanding, etc.)

“Diagnosis-Related Group (DRG)” is a classification system for hospital admission. It allows providers/hospitals to bill a specific DRG code as classified by organ systems and then the specific subgroup. Codes are also classified as surgical or medical.

"Major Diagnostic Category (MDC)" is a classification system that is implemented alongside the DRG system. It is formed by further dividing all possible principal diagnoses from the International Statistical Classification of Diseases into 25 mutually exclusive diagnosis areas.

Readmissions Policy Criteria

Oscar flags readmissions that fall in the below criteria:

The readmission occurred within the specified time interval, as defined as one of the following, and:

a. Within 30 days of the initial discharge; or
b. Within 30 days of a prior preventable readmission meeting the below criteria
    i. The readmission occurred within the same inpatient hospital or health system; and
    ii. The readmission is the same MDC and same DRG as the initial admission, implying the member is readmitted for reasons clinically related to the initial admission; or
c. Within 30 days of a prior preventable readmission meeting the below criteria
    i. The readmission occurred within the same inpatient hospital or health system; and
    ii. The readmission is the same MDC as the initial admission, implying the member is readmitted for reasons clinically related to the initial admission

Readmissions Policy Reimbursement Guidelines

1. If readmission is of the same MDC and DRG as the initial admission, the payments will be bundled. We will not reimburse another DRG for members who are readmitted to the same facility for symptoms related to the prior stay's medical condition within 30 calendar days.

2. If readmission is of the same MDC as the initial admission, the payments will be bundle and the larger paying DRG will be reimbursed
    a. Ex. If the first DRG is a larger amount, we will not reimburse the second claim. If the second claim is larger, we will pay the difference in what was already paid in the first claim and second claim to equal the second claim's DRG payment.

Exclusion Criteria

Oscar may consider a readmission unavoidable and eligible for reimbursement when one of the following criteria is met:

1. Planned Readmissions, as specified in patient discharge status; or
2. Patient-initiated discharge "against medical advice" (AMA), as specified in patient discharge status; or
3. MDC codes that result in frequent member readmissions (Ex. MDC 17; Myeloproliferative Disorders or Poorly Differentiated Neoplasms); or
4. Contractual exclusions, if applicable

Publication History

Date	Action/Description
12/09/2015	Original Documentation
6/16/2016	Approval and inclusion in Oscar Provider Manual
4/18/2017	Policy updated
12/22/2020	Policy updated

Mid-level Providers

Policy:

This policy describes reimbursement made to mid-level providers.

Reimbursement:

Oscar follows guidelines established by CMS pertaining to mid-level providers. For the specialities listed in the table below, Oscar's reimbursement is equal to the lesser of 80% of billed charges and 85% of the allowed amount for physicians.

Specialty
Physician Assistant
Nurse Practitioner
Certified Clinical Nurse
Nurse Midwife
Certified Surgical Assistant

Publication History

Date	Action/Description
10/14/2016	Original Documentation
10/14/2016	Approval and inclusion in Oscar Provider Manual

Never Events

Policy

An adverse event is defined as an injury caused by medical management rather than by the underlying disease or condition of the patient. A subcategory, Never Events, are medical errors that are particularly severe due to their preventability. Never Events include errors such as performing surgery on the wrong body part, leaving a foreign object inside a patient after surgery, or discharging an infant to the wrong person.

Oscar will deny reimbursement to hospitals and providers for any costs incurred for treatment of Never Events. Oscar has adapted guidance from the National Quality Forum on Serious Reportable Events (SRE), the CMS Medicare Hospital Acquired Conditions (HAC), and Present on Admission (POA) indicator reporting.

Reimbursement Guidelines:

Oscar identifies, reviews, and monitors incidences of serious reportable adverse events and hospital acquired conditions to ensure providers are rendering high quality care and appropriate reimbursement is rendered.

Oscar will not reimburse professional or facility charges when:

- treatment or services rendered are directly related to the occurrence of the Never Event
- treatment or services rendered are related to the the correction or remediation of the Never Event
- treatment or services rendered are related to subsequent complications arising from the occurrence of the Never Event
- follow-up services or readmission for the Never Event are performed by the same provider or a provider owned by the same parent organization
- follow-up services or readmission for the Never Event are performed in the same facility

Any professional provider associated with a Never Event (surgeon, anesthesiologist, radiologist, etc.) is not eligible for reimbursement. Reimbursement is also not provided for any services in the operating or procedure room where the incorrect surgery error occurs.

Providers are strictly prohibited from billing members for copayments, coinsurance, deductible charges. This includes attempts to balance bill members for events and post-event related services, which are designated as ineligible for payment.

Publication History

Date	Action/Description
12/09/2015	Original Documentation
6/16/2016	Approval and inclusion in Oscar Provider Manual
4/18/2017	Policy updated
9/30/2017	Policy updated

Evaluation and Management Services

Policy

Oscar incorporates standards established by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) for our evaluation and management (E&M) services reimbursement policy. All services should be coded to the appropriate level of care, as laid out in the CMS and AMA guidelines, and should be able to be substantiated by medical records.

Reimbursement Guidelines

Modifiers

Code modifiers used for E&M services billing should be appropriate for the services rendered and **should** be able to be supported by medical records. Oscar may request medical records to ensure that included modifiers adhere to the standards outlined by the CMS and AMA.

Multiple Visits Per Day

Oscar will reimburse one visit per billing group, per subspecialty, per day. If both preventive and problem-oriented services are billed, and the problem-oriented visit is billed with modifier 25, Oscar will reimburse the higher-valued procedure at 100% of the otherwise allowable amount and the low
er-valued procedure at 50% of the contracted rate. Minor problem-oriented visits and problem-oriented codes billed without modifier 25 will not be reimbursed. Other E&M Services will be paid at 100% when billed with modifier 25, unless addressed below.

Screening/Counseling/Nutrition Therapy/Prolonged Services/Overlapping E&M Services

If a screening, counseling, nutrition therapy, prolonged, or otherwise overlapping E&M service is coded with modifier 25 and billed on the same day as a preventive E&M service as defined in the coding section below, Oscar will reimburse 50% of the otherwise allowable amount for the non-preventative service. Otherwise, these services are not separately payable when billed on the same day as preventive E&M services by the same provider.

Examples of and exceptions to this policy are listed in the coding section below.

Bundled Services

The following services are not separately payable when billed on the same day as specific E&M services.

- Annual wellness visits are bundled into preventative visits
- Cervical or vaginal cytopathology is bundled into preventive or problem-oriented visits
- Collection of blood from an Implantable venous access device or venous catheter is bundled into problem-oriented visits
- Screening pap smears are bundled into preventative visits
- Screening pelvic/breast/rectal examinations are bundled into preventive and problem-oriented visits

- Interpretation and report of ECG is bundled into problem-oriented, inpatient, or ED visits
- Interpretation and report of cardiovascular stress tests are bundled into ED visits
- Interpretation of chest X-rays are bundled into ED and inpatient visits
- Preventive medicine counseling is bundled into preventative visits
- Removal of impacted earwax is bundled into any E&M visit
- Pulse oximetry is bundled into any E&M visit

Services During Global Periods

E&M services are not separately payable when provided on the same day (or the day prior, for major surgical procedures) as a procedure with a global period, as defined by the CMS or Oscar (for codes with global surgery indicator YYY). Exceptions to this policy are for significant and separately identifiable services performed on the same day as the global procedure, when billed with modifier 25, or for services resulting in a decision to perform a major surgery, when billed with modifier 57. For services billed with modifier 25, the lesser of the procedure or E&M rate is paid at 50% of the contracted rate.

E&M services provided within the global period, during the postoperative period, are not considered separately payable unless unrelated to the original procedure and billed with modifier 24.

Emergency Department (ED) Facility E&M Coding

Facilities are entitled to submit CPT E&M codes on a UB form in addition to the E&M's submitted by the ED physician. Facility resource consumption drives the eligible E&M level submitted whereas physician resources drive the physician ED E&M level as outlined by CPT. An E&M visit level evaluation tool that accounts for diagnoses submitted as well as facility services ordered and performed determines the likely appropriate level of the facility E&M reimbursement. Given the inherent variability and complexity relating to the higher level E&M codes (99283, 99284, or 99285) the evaluation tool will verify whether the higher level codes are accurately reflecting the complexity of the visit and if not, the ED E&M reimbursement will reflect the tool output. Since the focus is on purely the level 3,4 and 5 codes, coding recommendations will only focus on a reduction in code levels. This will result in:

1. Fair and appropriate facility reimbursement for ED services rendered

2. Reduction in facility up coding and corresponding overpayment

CMS indicates facilities should bill appropriately and differentially for outpatient visits, including emergency department visits. To that end, CMS coding principles applicable to emergency department services provide that facility coding guidelines should: follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code; be based on hospital facility resources and not based on physician resources; and not facilitate upcoding or gaming.

Consultation Codes

Oscar will reimburse outpatient consultation E&M codes at the equivalent problem-oriented E&M visit rate, inpatient consultations at the equivalent inpatient visit E&M code, and emergency department consultations will be reimbursed at the equivalent Emergency department E&M code. For inpatient visits, the admitting physician must submit the visit with modifier 'AI' in order for the consulting physician to be reimbursed.

Non-Reimbursable Services

Oscar does not reimburse the following services: Transitional care management, advance care planning, chronic care management services, or prolonged services provided in an inpatient setting or by clinical staff.

Coding

Categories identified above include, but are not limited to, the below codes.

Code	Description
99381-99387,99391-99397, G0402	Preventive E&M Services
99201-99205,99211-99215	Problem-Oriented E&M Services
99281-99285	Emergency Department E&M Services
99224-99226	Observation E&M Services
99221-99223,99231-99236	Inpatient E&M Services
G0438, G0439	Annual Wellness Visits
88141-88155, 88164-88167, 88174-88175	Cervical or Vaginal Cytopathology
36591, 36592	Collection of Blood from an Implantable Venous Access Device or Venous Catheter
Q0091	Screening Pap Smear
G0101	Screening Pelvic and Clinical Breast Examination
G0102	Screening Rectal Exam
93010, 93042	Interpretation and Report of ECG
93018	Interpretation and Report of Cardiovascular Stress Test
71045, 71046	Interpretation of Chest X-ray
99401-99404, 99411, 99412	Preventive Medicine Counseling
69209, 69210	Removal of Impacted Earwax
94760-94672	Pulse Oximetry
99172, 99173, 99408, 99409, G0396, G0397, G0442, G0444	Screening Services
99406, 99407, 99411, 99412, G0245, G0246, G0296, G0443, G0445-G0447, G0473, H0005, S0257, S0265, T1006, T1027	Counseling Services
G0270, G0271, S9470	Nutrition Therapy Services

99354, 99355	Prolonged Services provided by a Physician in Outpatient Setting
99241-99245, 99251-99255, 99281-99285, G0245, G0246, S0285	E&M Services overlapping with Preventative Services
99241-99245	Outpatient Consultation E&M Services
99251-99255	Inpatient Consultation E&M Services
99495, 99496	Transitional Care Management
99497, 99498	Advance Care Planning
99415, 99416	Prolonged Services provided by Clinical Staff
99356, 99357	Prolonged Services provided in Inpatient Setting
99487-99490	Chronic Care Management

Publication History

Date	Action/Description
4/02/2017	Original Documentation
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7/20/2017	Policy Updated
8/29/2018	Policy Updated
4/09/2019	Policy Updated
3/26/2020	Policy Updated
6/10/2020	Policy Updated

Drug Testing

Policy

Drug testing describes measuring for the presence or quantity of a drug in a patient's system.

Reimbursement Guidelines

Drug Test Codes
Oscar only reimburses for specific, multiple drug class CPT and HCPCS codes for presumptive and definitive drug tests, as outlined below. Oscar considers all other drug testing codes to be unbundled and will not be reimbursed if billed.

Definitive Testing Requirement
Definitive drug testing services will be reimbursed only when conducted after a positive presumptive drug test.

Quantity Limits
Oscar will reimburse up to one definitive or one presumptive drug test per date of service, limited to 20 reimbursable units total per plan year.

Bundled Services
The following services are not separately payable when billed on the same day as specific drug testing services.

- Column chromatography/mass spectrometry is bundled into presumptive and definitive drug tests

Coding

Categories identified above include, but are not limited to, the below codes.

Code	Code Category
80305-80307, G0477-G0479	Presumptive Drug Test
G0480-G0481, G0659	Definitive Drug Test
82541-82544	Column Chromatography/Mass Spectrometry
80150-80203, 80320-80374, 83992	Unbundled Codes (not reimbursed)

Publication History

Date	Action/Description
4/02/2017	Original Documentation
4/20/2017	Approval and inclusion in Oscar Provider Manual
8/29/2018	Policy Updated
8/29/2019	Policy Updated

Surgical Techniques

Policy

Surgical techniques are methods that utilize supplemental devices or practices to conduct a surgical procedure.

Reimbursement Guidelines

Robotic Assisted Surgery
Oscar does not separately reimburse Robotic Assisted Surgery (HCPCS Code S2900), as it is integral to the primary surgical procedure.

Operating Microscope
Oscar does not separately reimburse the use of an operating microscope (CPT Code 69990) during surgery, considering it integral to the primary surgical procedure.

Publication History

Date	Action/Description
4/02/2017	Original Documentation
4/20/2017	Approval and inclusion in Oscar Provider Manual

Bundled Services

Policy

Oscar considers payment for certain services to be already factored into the reimbursement for other services. Oscar will not make a separate payment for the bundled service when conducted by the same provider in the same session.

Reimbursement Guidelines

Bundled Services

The following services are not separately payable when billed on the same day with a service that they are identified as being bundled into.

- Codes identified with status code 'B' or 'T' in the National Physician Fee Schedule RVU file are always considered bundled
- Codes identified with status code 'P' in the National Physician Fee Schedule RVU file are bundled into any service rendered outside the patient's home
- Routine Venipuncture is bundled into any other rendered service
- Cast supplies are bundled into custom foot orthotics
- CT guidance for insertion of radiation therapy fields is bundled into management of radiation therapy
- Continuous Intraoperative monitoring inside the OR is bundled into continuous Intraoperative monitoring outside the OR
- Diagnostic esophagogastroduodenoscopy (EGD) is bundled into laparoscopy, surgical, and gastric restrictive procedures
- Digital analysis of electroencephalogram (EEG) is bundled into monitoring for localization of cerebral seizure focus
- Electrical stimulator supplies are bundled into electrical stimulation modalities
- Electrodes are bundled with other services such as electrocardiograms (ECG), electroencephalograms (EEG), stress tests, sleep studies, electrical stimulation modalities, and acupuncture
- Electrodes and lead wires are bundled into electrical stimulator supplies
- Electrodes reported are bundled into conductive gel or paste
- Electroencephalograms and intraoperative neuromonitoring are bundled into electrocorticograms
- Electromyography is bundled into intraoperative neuromonitoring
- Home infusion therapy professional pharmacy services, drug administration, equipment, and/or supplies are bundled into any per diem home infusion therapy (HIT) service
- Intravenous vascular introduction is bundled into injection and infusion services
- Major arthroscopic knee synovectomy is bundled into arthroscopic knee surgeries
- Needles are bundled into acupuncture services
- Open capsulectomy is bundled into delayed insertion of breast prosthesis
- Radiological supervision and interpretation of transcatheter therapy is bundled into injection of sclerosing solution

- Regional or local anesthesia is bundled when performed within a physician office
- Removal of impacted earwax is bundled with with audiologic function testing
- Replacement soft interface material is bundled with continuous passive motion devices
- Needles and injection supplies are bundled with injection and infusion services
- Time based therapeutic behavioral services are bundled with per diem therapeutic behavioral services
- Therapeutic, prophylactic, and diagnostic injections and infusions are bundled with nuclear medicine testing
- Tissue markers are bundled with placement of breast localization device(s) and/or percutaneous placement of breast localization device(s)
- Ultrasonic guidance for needle placement is bundled with codes defined as including ultrasonic guidance

Coding

Categories identified above include, but are not limited to, the below codes.

Code	Description
A4580, A4590, S0395	Cast Supplies
36415	Routine Venipuncture
L3000, L3010, L3020, L3030	Custom Foot Orthotics
77014	CT Guidance for Insertion of Radiation Therapy Fields
77280, 77285, 77290	Management of Radiation Therapy
95940	Continuous Intraoperative Monitoring inside the OR
95941	Continuous Intraoperative Monitoring outside the OR
43235	Diagnostic Esophagogastroduodenoscopy (EGD)
43770-43775	Laparoscopy, Surgical, and Gastric Restrictive Procedures
95957	Digital Analysis of Electroencephalogram (EEG)
95950-95956	Monitoring for Localization of Cerebral Seizure Focus
A4595	Electrical Stimulator Supplies

97014, 97032	Electric Stimulation Modalities
A4556	Electrodes
93000, 93005, 93010, 93025, 93224, 93225, 93226, 93227, 93228, 93229, 93268, 93270	Electrocardiograms (ECG)
95829	Electrocorticograms
95812, 95813, 95816, 95819, 95822, 95824, 95827, 95829, 95950, 95951, 95953, 95954, 95955, 95956, 95957, 95958, 95961, 95962	Electroencephalograms (EEG)
95860, 95861, 95867, 95868, 95870	Electromyography
93015, 93016, 93017, 93018	Stress Tests with ECG
95800-95807	Sleep Studies
97810-97814	Acupuncture
A4557	Lead Wires
A4558	Conductive Gel and Paste
S9810	Home Infusion Therapy Professional Pharmacy Services for Drug Administration
A4221, A4222, E0776, E0781	Home Infusion Therapy Equipment and Supplies
S5492-S5502, S9061, S9325-S9379, S9490-S9504, S9537-S9590	Per Diem Home Infusion Therapy Service
36000	Intravenous Vascular Introduction
96360, 96365, 96374, 96375, 96376, 96405, 96406, 96409, 96413, 96416, 96440, 96446, 96450, 96542	Injection and Infusion Services
29876	Major Arthroscopic Knee Synovectomy
29880-29883	Arthroscopic Knee Surgeries
A4215	Needles
19371	Open Capsulectomy
19342	Delayed Insertion of Breast Prosthesis

75894	Radiological Supervision and Interpretation of Transcatheter Therapy
36468, 36469, 36470, 36471, 45520, 46500	Injection of Sclerosing Solution
J2001, J3490	Regional or Local Anesthesia
69210, G0268	Removal of Impacted Earwax
92551-92557, 92561-92588, 92596	Audiologic Function Testing
E1820	Replacement Soft Interface Material
E0935-E0936	Continuous Passive Motion Devices
A4206-A4209, A4212, A4213, A4215-A4217, A4221 -A4223, A4244-A4248, A4550, A4649, A4657, A4930	Injection Supplies
H2019	Time based Therapeutic Behavioral Services
H2020	Per Diem Therapeutic Behavioral Services
96365, 96369, 96372-96374, 96379	Therapeutic, Prophylactic, and Diagnostic Injections and Infusions
78012-79999	Nuclear Medicine Testing
A4648	Tissue Marker
19081-19101, 19281-19288	Placement of Breast Localization Device(s) and/or Percutaneous Placement of Breast Localization Device(s)
76942	Ultrasonic Guidance for Needle Placement
10030, 19083, 19285, 20604, 20606, 20611, 27096, 32554-32557, 37760, 37761, 43232, 43237, 43242, 45341, 45342, 64479-64484, 64490-64495, 76975	Codes defined as including Ultrasonic Guidance

Publication History

Date	Action/Description
4/01/2017	Original Documentation

4/20/2017	Approval and inclusion in Oscar Provider Manual
8/29/2018	Policy Updated

Radiology

Policy

Oscar reimburses for radiology services to treat or diagnose medical conditions subject to coverage, medical necessity, and policy restrictions.

Reimbursement Guidelines

Radiology Performed with E&M Service
Oscar will not separately reimburse the professional component of radiology services when provided on the same date of service as an E&M service in an office setting by the same provider.

Multiple Radiology Procedures
When multiple radiology procedures eligible for multiple procedure discounting (CPT/HCPCS code where the CMS NPFS Status Indicator is equal to 4) are performed on the same day by the same provider, Oscar will apply a reduction to the technical and professional component reimbursement for the additional services. Oscar will reimburse the technical component of the highest value procedure at 100% and the technical component of all subsequent procedures at 50%. Oscar will reimburse the professional component of the highest value procedure at 100% and the professional component of all subsequent procedures at 95%.

PET Scans
Oscar requires PET scans to be billed with a PI or a PS modifier to be considered reimbursable.

Contrast Media
Oscar considers specific contrast media codes to be never separately reimbursable from the radiology procedure. Oscar also considers some codes to only be reimbursable when provided in conjunction with an appropriate service.

Coding
Categories identified above include, but are not limited to, the below codes.

Code	Description
A9515, A9526, A9536, A9546, A9550, A9552, A9555, A9559, A9566, A9576, A9577, A9578, A9579, A9580, A9581, A9583, A9585, A9586, A9587, A9588, A9698, A9597, A9598, A9700, Q9951, Q9953, Q9954, Q9958, Q9959, Q9960, Q9961, Q9962, Q9963, Q9964, Q9965, Q9966, Q9967, Q9968	Contrast Media Never Separately Reimbursed

78608, 78811, 78812, 78813, 78814, 78815, 78816	PET Scans

The below table lists the contrast media codes that must be billed with an appropriate service, as well as the appropriate services for that code.

Contrast Media Code	Required Service Code
A9500	78451-78454, 78070-78072, 78605-78607, 78800-78804
A9502	78451-78454, 78070-78072, 78803
A9503	78300-78320
A9505	78451-78454, 78070-78072, 78800-78804, 78607
A9507	78800-78804
A9508	78075, 78800-78804
A9509	78000-78018, 78020, 78070-78072
A9510	78226, 78227
A9512	78012-78018, 78600-78607, 78610, 78481, 78483, 78261, 78290, 78291, 78070-78072, 78230-78232, 78730, 78740, 78630-78650, 78660, 78761
A9516	78012-78018,78070-78072
A9521	78600-78607, 78610
A9524	78110-78111, 78122, 78600-78607, 78610, 78579-78598, 78451-78454, 78800-78804, 78472-78473, 78481-78483
A9520	78195
A9528	78012-78018, 78803, 78012-78018, 78803, 78012-78018, 78803
A9537	78226, 78227
A9538	78300-78320, 78466-78469
A9539	78579-78598, 78761, 78700-78725, 78730, 78740, 78630-78650, 78600-78607, 78610, 78291, 78645, 78481, 78483, 78445,78428
A9540	78579-78598, 78291, 78216, 78428, 78201, 78205, 78215, 78800, 78801, 78803
A9541	78201-78216, 78185, 78278, 78102-78104, 78264, 78265, 78266, 78258, 78262, 78740, 78730, 78195, 78291
A9542	78804

A9547	78805-78807, 78185, 78190-78191
A9548	78630, 78635,78645,78647, 78650, 78800
A9551	78700-78710, 78800-78804
A9553	78120-78122, 78130-78135, 78140, 78190-78191, 78707-78709, 78725
A9554	78707-78709, 78725
A9556	78800-78807
A9557	78600-78607, 78610
A9558	78579-78598
A9560	78472, 78473, 78494, 78496, 78278, 78201-78206, 78445, 78457-78458, 78215, 78216, 78185
A9561	78300-78320
A9562	78700-78725
A9567	78579-78598
A9569	78805-78807
A9570	78805-78807, 78185
A9571	78190-78191
A9572	78075, 78800-78804, 78015-78018
A9582	78075, 78800-78804

Publication History

Date	Action/Description
7/13/2017	Original Documentation
9/30/2017	Approval and inclusion in Oscar Provider Manual
8/29/2018	Policy Updated

Add-on Codes

Policy

Add-on codes are specific supplemental codes that describe services provided by a physician in addition to the primary service. Add-on codes are performed by the same physician during the same patient encounter.

Oscar will only reimburse add-on codes if the correct primary code is billed and eligible for payment.

Reimbursement Guidelines:

Add-on codes must be reported on the same claim as the primary code. The primary code must also be related and appropriately paired with the correct add-on code based on the CMS Add-on edit tables.

If an add-on code is billed with the incorrect primary code or without a primary code, it is not eligible for reimbursement. There is no modifier that can bypass a denial for an add-on code violation.

Clinical edits for the primary code can also affect the add-on codes. Per NCCI guidelines, if a clinical edit is applied to a primary code and prevents it from being paid, the add-on code will not be paid.

Oscar follows CMS guidelines to determine primary / add-on code pairings.

Publication History

Date	Action/Description
09/30/2017	Original Documentation
09/30/2017	Approval and inclusion in Oscar Provider Manual

Incident-To Services

Policy

Oscar does not recognize or allow incident-to billing. All practitioners must bill the services they provide under their own name and provider identification information.

Publication History

Date	Action/Description
09/30/2017	Original Documentation
09/30/2017	Approval and inclusion in Oscar Provider Manual

Durable Medical Equipment

Policy

Oscar reimburses for Durable Medical Equipment (DME) subject to coverage, medical necessity, and policy restrictions. Durable Medical Equipment must be able to withstand repeated use, is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience, generally not useful to someone who isn't sick or injured, appropriate for use within the home or otherwise outside a medical facility or may be necessary for use at other locations or in the community to allow basic activities of daily living, and prescribed by a licensed physician or practitioner.

Reimbursement Guidelines

Rental DME

Oscar will reimburse rental DME until the total purchase price has been paid or 10 months of rental payments, whichever comes first. After the cap has been reached, the equipment is considered purchased.

Exceptions to the Rental DME policy include:

- Oxygen equipment and DME defined as 'frequently serviced' by CMS is exempt from the cap.
- DME defined as 'Capped Rentals' by CMS will be reimbursed up to 10 months of rental payments, at which point the equipment is considered purchased

Coding

Categories identified above include, but are not limited to, the below codes.

Modifier	Description
NU	New Equipment
RR	Rental Equipment
UE	Used Equipment

Publication History

Date	Action/Description
7/25/2021	Original Documentation
8/27/2018	Approval and inclusion in Oscar Provider Manual

Physician-Administered Drugs

Policy

Oscar reimburses providers for physician-administered drugs subject to coverage, medical necessity, and policy restrictions.

Reimbursement Guidelines

NDC Billing Requirements:
The following HCPCS codes require an NDC to be billed:

- J codes, including miscellaneous and unlisted drug codes
- Drug-related CPT codes, including miscellaneous and unlisted drug codes, immunizations, Synagis and Immune Globulin
- Drug-related Q codes, including miscellaneous and unlisted drug codes, and Contrast
- Drug-related S codes
- Drug-related A codes, including miscellaneous and unlisted drug codes, and Radiopharmaceuticals

Unit of Measure Billing Guidelines:
In order to ensure consistent and correct processing of claims, the units and unit of measure must be correctly reported. Both HCPCS and NDC units must be submitted accurately based on the unit of measure defined by the HCPCS and NDC codes. The NDC unit of measure must be correctly reported based on the below guidelines. These guidelines are adapted from the National Council for Prescription Drug Programs (NCPDP) Billing Unit Standard (BUS).

"UN" (unit) is used when the product is dispensed in discrete units. These products are not measured by volume or weight. The Billing Unit of "UN" is also used to address exceptions where "GM" and "ML" are not applicable. Examples of products defined as "UN" include but are not limited to:

- Tablets
- Capsules
- Suppositories
- Transdermal patches
- Non-filled syringes
- Tapes
- Blister packs
- Oral powder packets
- Powder filled vials for injection
- Kits

- Unit-of-use packages with a quantity less than one milliliter or gram should be billed as “one each”. For example, ointment in packets of less than 1 gram or eye drops in droppettes that are less than 1 ml. This rule does not apply to injectable products.
- Antihemophilic Products

“ML” (milliliter) is used when a product is measured by its liquid volume. Examples of products defined as “ML” include but are not limited to:

- Liquid non-injectable products of 1 ml or greater
- Liquid injectable products in vials/ampoules/syringes
- Reconstitutable non-injectable products at the final volume after reconstitution except when they are in powder packets
- Inhalers (when labeled as milliliters on the product)

“GM” (gram) is used when a product is measured by its weight. Examples of products defined as “GM” include but are not limited to:

- Creams (of 1 gram or greater)
- Ointments (of 1 gram or greater)
- Inhalers (when labeled as grams on the product)

Convenience Kits:

Point-of-use convenience kits are non-reimbursable. These kits typically contain injectable drugs as well as the medical supplies required to administer the injection. The components of these kits must be billed separately to be considered for reimbursement. The practice expense payment for a given procedure frequently already includes the payment for these supplies.

Publication History

Date	Action/Description
7/23/2018	Original Documentation
8/27/2018	Approval and inclusion in Oscar Provider Manual
4/10/2019	Policy Updated

Intraoperative Neuromonitoring

Policy

Oscar reimburses for Intraoperative Neuromonitoring (IONM) subject to coverage, medical necessity, and policy restrictions. Physicians performing IONM can be in the operating suite or remote, but must be able to communicate in real-time with the surgeon.

Reimbursement Guidelines

Concurrent Monitoring
Oscar will not reimburse IONM when a physician is monitoring more than 3 cases simultaneously.

Time Reporting
For continuous intraoperative monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, increments of less than 30 minutes should not be billed. For continuous intraoperative neurophysiology monitoring in the operating room with one on one monitoring requiring personal attendance, increments of less than 8 minutes should not be billed. The period of billable neuromonitoring includes intraoperative time only, which does not have to be continuous.

Billing
IONM must be performed by a licensed physician to be eligible for reimbursement when billed on a HCFA-1500 form.

Publication History

Date	Action/Description
7/18/2018	Original Documentation
8/27/2018	Approval and inclusion in Oscar Provider Manual

Services Delivered via Telemedicine

Policy

Oscar reimburses providers for medically necessary, covered services delivered via telemedicine or telehealth subject to federal and state regulatory restrictions.

This policy describes reimbursement for services delivered via telemedicine or telehealth, which occur when the physician or other qualified health care professional and the patient are not at the same site. Examples of such services are those that are delivered over the Internet or using other communication devices.

Definitions

See applicable state law for applicable definitions related to provision of services via telehealth or telemedicine.

Reimbursement Guidelines

Oscar reimburses services offered via telehealth or telemedicine in accordance with applicable state law and the Member's Evidence of Coverage (Policy).

Providers shall be:

- Validly licensed, certified, or registered to provide such services as required by applicable state law;
- Subject to regulation by the appropriate State licensing board or professional regulatory entity;
- In compliance with existing requirements requiring the maintenance of liability insurance; and,
- In compliance with applicable data security, patient confidentiality, and privacy regulations . A secured electronic channel is required to be utilized by a telemedicine provider. All transactions and data communication must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

For all lines of business, Oscar will consider for reimbursement Telehealth services which are recognized by the Centers for Medicare and Medicaid Services (CMS) and appended with modifiers GT or GQ, as well as services appended with modifier 95.

Oscar requires one of the following modifiers to be reported when performing a service via Telehealth to indicate the type of technology used and to identify the service as Telehealth. Oscar will consider reimbursement for a procedure code/modifier combination using these modifiers only when the modifier has been used appropriately.

Please see below for examples of referenced codes:

Coding Definitions

POS	Description
02	Telemedicine

Modifier	Description
GT	Services offered via Interactive Audio and Video Telecommunications systems.
GQ	Services offered via Asynchronous Telecommunications systems
95	Services offered via Synchronous interactive audio and video telecommunications systems

Categories of services that may be covered when provided telehealth or telemedicine include, but are not limited to, the below codes.

Code	Description
99201	Problem focused exam and history and straightforward MDM.
99202	Expanded exam and history and straightforward MDM.
99203	Detailed exam and history and low MDM.
99204	Comprehensive exam and history and moderate MDM.
99205	Complex exam and history and high MDM.
99211	Problem focused exam and history and straightforward MDM.
99212	Expanded exam and history and straightforward MDM.

99213	Detailed exam and history and low MDM.
99214	Comprehensive exam and history and moderate MDM.
99215	Complex exam and history and high MDM.
99441	Telephone evaluation and management service by a physician or other qualified healthcare professional, 5-10 minutes of medical discussion
99442	Telephone evaluation and management service by a physician or other qualified health care professional, 11-20 minutes of medical discussion
99443	Telephone evaluation and management service by a physician or other qualified health care professional, 21-30 minutes of medical discussion
99421	Online digital evaluation and management service for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99422	Online digital evaluation and management service for up to 7 days, cumulative time during the 7 days; 11-20 minutes
99423	Online digital evaluation and management service for up to 7 days, cumulative time during the 7 days; 21 or more minutes

*MDM=Medical Decision Making

Publication History

Date	Action/Description
8/20/2019	Approval and inclusion in Oscar Provider Manual
9/29/2020	Revised to include new codes

Technicals Denials

Policy

A technical denial is a denial of the entire billed or paid amount of a claim in instances when the care provided to a member cannot be substantiated due to a healthcare provider's lack of response to Oscar's requests for medical records, itemized bills, documents, etc.

Documentation requested from healthcare providers must be received within 90 days (unless applicable state, federal, or contract laws specify a different time frame).

Reimbursement Policy:

Prepayment review technical denials
For prepayment reviews, medical records and/or related documentation will be reviewed for appropriate coding, documentation, and Medical Necessity as appropriate. When additional documentation is needed for Oscar to adjudicate the claim, the claim will be pended until the documentation is received or until the deadline for receipt of the documentation passes.

- Records request: A letter will be mailed or faxed to the healthcare provider asking that records be provided within 90 days from the date of the letter, unless applicable state, federal, or contract laws specify a different time frame.
- Explanation of remittance (EOR) notification: If the requested records are not received within the required time frame (90 days at latest), the healthcare provider will receive an EOR showing the full denial of the claim due to lack of documentation to substantiate the services billed.

Post-payment review technical denials
For post-payment reviews, medical records and/or related documentation will be reviewed as outlined in the Oscar's reimbursement policy specifications.

- Records request: A letter will be mailed or faxed to the healthcare provider asking that records be provided within 90 days from the date of the letter.
- Request for refund or Offset: If the requested records are not received within the required time frame (95 days at latest) of the final notice, Oscar will issue a technical denial, and will pursue a request for refund or offsetting request.

After the request for refund/offset request goes out, the healthcare provider The healthcare provider will have 45 days from the date on the request-for-refund letter to send a refund check before the paid amount of the claim is offset or recouped, (unless applicable state, federal, or contract laws specify a different time frame).

Publication History

Date	Action/Description
4/7/2021	Approval and inclusion in Oscar Provider Manual
3/18/2021	Original Documentation