Claims, Billing and Provider Reimbursement

Claims ................................. 169
Billing ................................. 182
Provider Reimbursement ........ 185
Claims

Explanation of the Claims Process

Time Frame for Commercial and Medicare Claims Submission

Providers and facilities are required to submit claims within 90 days of the date(s) of service, after a commercial or Medicare Member has been seen. Untimely claims will be denied. The claims filing deadline is based on the date of service on the claim. It is not based on the date the claim was sent or received by Oxford.

Oxford strives to process all complete claims within 30 days of receipt. Providers have a variety of methods available to verify and ensure that claims are received by Oxford within the filing deadline.

If a provider does not receive a Remittance Advice within 45 days, he or she should check the status of the claim at that time. Oxford offers providers multiple tools for checking claims status:

- Oxford Express® (automated self-service system) at 1-800-666-1353 (available 24 hours a day, seven days a week)
- Oxford’s web site at www.oxfordhealth.com available 24 hours a day, seven days a week
- Provider Services at 1-800-666-1353 (Mon. - Fri., 8 AM - 6 PM)

Exceptions:

- If a claim is disputed, you have 180 days from the date of the Remittance Advice statement to appeal the claim, with the exception of claims for New Jersey Member, you have 90 days from the date of the Remittance Advice statement for such claims
- If an agreement currently exists between you and Oxford or UnitedHealthcare containing specific filing deadlines, that agreement will govern
- If coordination of benefits has caused a delay, you will need to provide proof of denial from the primary carrier and will have 180 days from the date of the primary carrier Explanation of Benefits to submit the claim to Oxford
- If the Member has a health benefits plan with a specific time frame regarding the submission of claims, the time frame in the Member’s Certificate of Coverage will govern

Claims submitted after the 90-day filing deadline that do not fit one of these exceptions will not be reimbursed; the reason stated will be “filing deadline has passed” or “services submitted past the filing date.”

Clean and Unclean Claims

Because Oxford processes claims according to state and federal requirements, a clean claim is defined as a complete claim or an itemized bill that does not require any additional information to process it.

A clean claim includes at least the following:

- Patient name and Oxford Member ID number
- Oxford provider ID number
- Provider information, including federal tax ID number (FTIN)
- Date of service
- Place of service
- Diagnosis code
- Procedure code
- Individual charge for each service
- Provider signature

An unclean claim is defined as an incomplete claim, a claim that is missing any of the above information or a claim that has been suspended in order to get more information from the provider. If you submit incomplete or inaccurate information, Oxford may reject the claim, delay processing or make a payment determination that must be adjusted later when complete information is obtained (e.g., denial, reduced payment).

Oxford applies the appropriate state and federal guidelines to determine whether the claim is not clean.

See Required Information for All Claims Submission in this section.
EDI Claims Submission Policy

Electronic claims submission is a critical step in our ongoing process to simplify and automate the entire payment process. Oxford has made significant investments in technology to facilitate the transmission and processing of electronic claims. As part of this effort, reimbursement of electronic claims is prioritized.

Please note: All healthcare providers can submit electronic claims to Oxford — regardless of whether or not they participate with Oxford.

Benefits of this process include:

- Faster claims turnaround time and reimbursement of clean claims
- Lower outstanding receivables
- Claims tracking at the point of submission
- Fewer errors and fewer subsequent delays in processing time
- Overall reduction in administrative expenses

Oxford recently established a policy that requires high-volume providers to submit all claims electronically. This policy was implemented to increase the number of electronic claims that Oxford receives from participating physician and ancillary practitioners who file high-volumes of paper claims. Oxford participating physicians and ancillary practitioners who submit over 100 claims to Oxford over a twelve-month period or submit less than 80 percent of their claims electronically are considered high-volume providers. High-volume providers are required to submit at least 90 percent of their claims electronically, subject to the exceptions below.

Exceptions

The policy does not apply to high-volume providers who meet at least one of the following:

- Submits less than 1,200 claims annually to all payors combined
- Provider plans to retire in less than one (1) year from the implementation date of this policy
- Provider plans to move or switch to a different practice in less than one (1) year from the implementation date of this policy
- Installs or converts hardware/software within six (6) months from the implementation date of this policy
- Falls under any further department of health exceptions
- Participates in a delegated arrangement with an Oxford contracted vendor and either (a) the vendor has not adopted this policy, or (b) Oxford has determined that the claims submitted directly to the vendor should be excluded from this policy, in either case, only the claims submitted to Oxford are included in this policy
- Installs or converts hardware/software within six (6) months from the implementation date of this policy
- Falls under any further department of health exceptions
- Installs or converts hardware/software within six (6) months from the implementation date of this policy
- Falls under any further department of health exceptions

Other exceptions may be granted on a case-by-case basis, pending review by Oxford’s Healthcare Services Department. In all other cases, the EDI Claims Submission Policy should be followed. High-volume providers who fail to submit claims electronically in accordance with Oxford’s Claim Submission Guidelines may be subject to an administration charge for each paper claim submitted.

In accordance with Oxford’s Claim Submission Guidelines, all claims can be submitted electronically with the exception of the following:

- Claims with Coordination of Benefits (COB) information
- Claims submitted with unspecified CPT and HCPCS procedure codes
- Claim resubmissions

See Paper Claims in this section for more information.

For more information or support on electronic claims, please call Oxford's Provider eSolutions Support Team at 1-800-599-4334.
The Provider eSolutions Support Team will monitor provider claim volumes quarterly and inform providers when they meet policy criteria and need to start submitting claims electronically. Oxford will determine if an administrative charge will be applied to those providers who are not in compliance.

**Submitting Electronic Claims**

**Required Information for Electronic Claims**

To expedite payment on electronic claims, Oxford must receive complete and accurate information from your office. Complete and accurate information requires you to provide Oxford’s Payor ID, which is **06111**, and the following required information listed in this section. Additionally, you will need to include information which is listed in this section under **Required Information for All Claims Submission**.

**Required Provider Information**

- **Oxford Provider ID Number** — Identification number assigned by Oxford to the provider (Example: BP123 or P123456)

- **Provider federal tax ID number** — Identification number assigned to the provider by the state

**Provider name** — Complete first name and last name of the provider rendering services (correct spelling assists Oxford with provider validation)

**Required Patient Information**

- **Confirmed eligibility** — Prior to submitting a claim, please confirm the patient’s current eligibility information through Oxford’s website at [www.oxfordhealth](http://www.oxfordhealth), Oxford Express® or one of Oxford’s EDI vendors.

- **Patient’s name and ID number** — Be sure to accurately enter the patient’s name and ID number as it appears on the patient’s Oxford ID card or the eligibility electronic transaction (correct spelling assists Oxford with Member validation); do not include the asterisk or space when entering the ID number; however, the last two bold numbers must be included (Example: 12345602)

- **Patient’s date of birth** — Be sure to confirm that this date is correct


**Covering Physician Information**

It is essential that the covering physician be included in the Remarks/Comments field of electronic claims being submitted to Oxford. This information should be included in the event that the Member’s selected physician is unavailable at the time services are performed, requiring an alternate/covering physician:

“Covering for Dr. [First Name, Last Name]”

To further ensure correct payment, the Oxford provider ID number of the physician being covered should also be included.
Durable Medical Equipment (DME) Claims
Because Oxford no longer requires our DME providers to send scripts with their DME claims, you can send these claims electronically. In order to ensure correct and timely payment, the following information must be included on your electronic DME claims:

- The referring provider’s name
- The words “Script on File” in the EDI Remarks field

Anesthesia Claims
The following information must be included on your electronic anesthesia claims to ensure correct and timely payment:

- Total number of minutes
- Number of units (one unit equals 15 minutes)
- Actual start time and end time in the Remarks/Comments field

Ambulance Claims
Oxford requires information on the “point of pickup” for ambulance services rendered to Oxford commercial and Medicare Members. Point of pickup refers to the complete address of the starting point of where the ambulance service begins.

For more information on electronic claims, please call Oxford’s Provider eSolutions Support Team at 1-800-599-4334.

Clearinghouses for Electronic Solutions
When your electronic claims are submitted, they are transmitted to a clearinghouse that checks for errors. If a clearinghouse determines the claim is free of errors, it is sent on to Oxford for processing. If errors are detected at Oxford, the claim is returned to you with an explanation of what was submitted incorrectly. You may then correct the errors and resubmit the claim. This process greatly reduces claim denials and expedites the correction process.

Oxford accepts electronic claims from the following clearinghouses:

- Emdeon™
- ENS
- Transaction Methods, Inc.
- ProxyMed
- NDC-Health
- Healthcare Data Exchange (HDX)
- McKesson HBOC (formerly CyData)
- Athena
- MISYS
- PerSe

Understanding Your Electronic Claims Reports
The reports you receive from a clearinghouse are crucial for maintaining control over your electronic claims. These reports are designed to help you understand the status of your claims, showing which claims have been accepted and forwarded to Oxford and which need to be resubmitted with corrections.
The format and content of electronic claim reports varies by clearinghouse. Many send two reports:

- The first type of report contains information regarding the total number of claims submitted, accepted and rejected by your clearinghouse; rejected claims will have detailed error explanations to assist you in understanding what information will be needed to resubmit your claim.
- The second type of report identifies claims that cannot be processed by Oxford; you must correct any errors and resubmit the claims electronically; claims that are rejected by a clearinghouse are not forwarded to Oxford.

**Provider eSolutions Support Team**

Oxford has a team of professionals dedicated to assisting you with electronic solutions for your administrative needs. They can also provide you with helpful information and assist you with a variety of topics related to EDI, including:

- Understanding the benefits of electronic claims
- Resolving problems with your practice management vendor
- Addressing issues with your clearinghouse
- Reading your electronic claims tracking reports
- Submitting electronic referrals
- Selecting hardware and software
- Topics related to [www.oxfordhealth.com](http://www.oxfordhealth.com)

For more information on electronic claims, please call Oxford’s Provider eSolutions Support Team at **1-800-599-4334**.

**Paper Claims**

Claims submitted with coordination of benefits (COB) information or unspecified CPT and HCPCS codes are exceptions to the electronic claim requirement and should continue to be submitted on paper CMS-1500 or UB-92 forms.

See section 1 on [Claims Submission Addresses](#) for a list of claim addresses.

**Time Frame for Processing Claims**

Oxford strives to settle all complete claims within 30 days of receipt. If you have not received payment within 45 days, and have not received a notice from Oxford about your claim, please use the contact information below to verify that Oxford has received your claim.

To check status of unpaid claims log in to Oxford’s provider web site at [www.oxfordhealth.com](http://www.oxfordhealth.com), call **Oxford Express® at 1-800-666-1353**, or Oxford's Provider Services Department at **1-800-666-1353**.

**Paid or Denied Claims**

When a claim is paid or denied, you will receive a check and/or an explanation that we refer to as a Remittance Advice statement. This will explain the payment in detail. Providers must accept Oxford’s fee schedules and reimbursement as payment in full. You may appeal a claims payment decision if you disagree with the determination.

See section 9 on [Appeals](#) for a full explanation.

In addition to your Remittance Advice, you can also check on the status of your claims using one of our electronic solutions. You can check the status of your claims on Oxford's web site, [www.oxfordhealth.com](http://www.oxfordhealth.com), using Oxford Express (Oxford's automated phone system) or through one of our EDI vendors.

**Corrected/Resubmitted Claims (Reconsideration Policy)**

To ensure prompt response when resubmitting a claim to Oxford, you must include the following:

- A completed CMS-1500 or UB-92 claim form with the corrected or resubmitted information
- The words “Corrected Claim” or “Resubmitted Claim” written or stamped in Field 19 [Reserved for Local Use] of the CMS-1500 form or Field 84 [Remarks] of the UB-92 Form
Section 8 — Claims, Billing and Provider Reimbursement

• A copy of Oxford's Remittance Advice or claim number written on the claim form in Field 19 [Reserved for Local Use] of the CMS-1500 form or Field 84 [Remarks] of the UB-92 form

Payment Appeals

See section 9 on Appeals for more information.

Claim Status Inquiry and Response

Benefits of the transactions include:

• **Flexibility** [web and EDI] — You have more search options for retrieving claim status information; the search capability allows providers to narrow searches by selecting from a range of optional inquiry data including claim ID numbers, extended date range, bill type, billed amount, CPT code and more; additionally, inquiries by Member Social Security number return all claims for all Oxford Member ID numbers associated with the requested Social Security number.

• **Increased efficiency in practice administration** [web and EDI] — Office administrators have the ability to inquire about submitted claims listed under the same federal tax ID number, allowing the user to conduct searches for all providers in a practice without having to log in using multiple passwords.

• **A global view** — Claim status responses include all claims that have been received by and forwarded to Oxford third-party vendors, such as CareCore National, OrthoNet, etc.

• **More detailed claim status and code sets** [web, EDI and interactive voice response (IVR)] — Claims show all relevant detailed statuses of a claim, both at the claim detail level and at the claim header level; this allows a full view of how claims are processed from beginning to end; HIPAA claim status codes consist of a combination of the following three code types:

  • **Status Category Code** — Defines the category of the status; claims are “Acknowledged,” “Pended” or “Finalized”.

  • **Status Code** — Identifies the reasoning behind the category location of a claim; for example, if a claim is paid at a contracted rate that explains the reason the claim is in the “Finalized” category.

**Please note:** Do not use a highlighter or red ink to communicate the issue in question, please use blue or black ink only. Also, we ask that you keep copies of all Remittance Advice documents from Oxford for your records.

Requests for Additional Information

There are times when Oxford will request additional information to process a claim. The request will either appear on the Remittance Advice or a separate communication. The requested information must be submitted promptly. If the information is not submitted within 45 days, an appeal must be submitted with the information.

**OXFORD | IMPORTANT ADDRESS**

Corrected/Resubmitted Claims (not requested by Oxford)

Oxford Health Plans
Attn: Correspondence Department
P.O. Box 7081
Bridgeport, CT 06601-7081

**OXFORD | IMPORTANT ADDRESS**

Corrected/Resubmitted Claims (requested by Oxford)

Oxford Health Plans
Attn: Corrected Claims Department
P.O. Box 7027
Bridgeport, CT 06601-7027
• **Entity Code** — Rarely used in the claim status response, this is used when business conditions apply or used under error conditions, such as when a Member or procedure code is not found; these codes further clarify the status category and status codes; status category and status codes will be used in most cases

Performance highlights include:

• **Timely information** — Claim inquiries are retrieved and returned within HIPAA-mandated time frames, 60 seconds for individual and multi-claim searches and 24 hours for batch inquiries

• **Consistent response** — All of Oxford’s electronic mediums including web, Oxford Express®, Oxford’s automated IVR system, and EDI communicate a consistent and HIPAA compliant claim status response; additionally, Oxford supports Batch EDI claim status inquiry transactions and enforces minor changes with its vendors

• **Fax-back option available for IVR claims** — The IVR claim status response offers you the ability to request and receive a faxed copy of the claims requested

---

**Claims Recovery Policy (for Individual Providers)**

In situations resulting from isolated mistakes or where the provider is in no way at fault, Oxford will not pursue collection of overpayments with individual participating providers that were made more than one year prior to the date of notice of the overpayment (the one-year period runs from the date of payment to the date Oxford provides notice to the provider. Discussions and actions to collect overpayments for which a provider is given notice within the one-year period are appropriate under this policy, Oxford will not use extrapolation, unless the situation fits into items 1, 2 or 3 below. This would include, but not be limited to, situations involving duplicate claims, overpayments related to fee schedule issues, isolated situations of incorrect billing/unbundling, and situations where Oxford was not the primary insurer. This policy does not apply to facilities or ancillaries.

1. Oxford has a reasonable suspicion of fraud or a sustained or high level of billing error.

2. A provider affirmatively requests additional payment on claims or issues older than one year, whether through suit, arbitration, or otherwise.

3. The Centers for Medicare & Medicaid Services (CMS) makes a retroactive change to enrollment or to primary versus secondary coverage of a Medicare enrollee, Oxford will pursue collection of past overpayments beyond one year and utilize statistical methods and extrapolation.

Cases involving a reasonable suspicion of fraud or a sustained or high level of billing error would include situations such as extensive or systemic upcoding, unbundling, misrepresentation of services or diagnosis, services not rendered, frequent waiver of Member financial responsibility, misrepresentation of provider rendering the services or licensure of such provider, and similar issues.
ICD-9-CM, CPT, HCPCS, and Place Codes

Oxford uses the International Classification of Diseases, 9th Revision, Clinical Modification Diagnosis and Procedure Codes (ICD-9-CM), Current Procedural Terminology (CPT), and the Healthcare Common Procedure Coding System (HCPCS) to determine payment. Providers must correctly use these codes on their claims in order to receive payment. Some codes are included in this manual; however, you can obtain complete lists of these codes by contacting St. Anthony’s Publishing:

St. Anthony’s Publishing
11410 Isaac Newton Square
Reston, VA 20190
1-800-632-0123, ext. 5814

In addition to the codes above, Oxford uses the bill type, occurrence codes and revenue codes, when applicable, to determine payment. You can obtain complete lists of these codes* by contacting the Centers for Medicare & Medicaid Services (CMS).

If any of the above information is not submitted correctly, the clearinghouse will return the claim to you so that you may correct the error(s) and resend the claim electronically.

* For information on additional HIPAA Code Sets, please refer to Appendix C of the 837 Health Care Claim: Professional ASC X12N (004010X98) Implementation Guide or the 837 Health Care Claim: Institutional ASC X12N (004010X96) Implementation Guide.

Required Information for All Claims Submissions

Using the Correct Fields on the CMS-1500 Form

The following information is required for claims processing. If this information is not provided, the claim will be suspended and payment withheld until you resubmit the claim with the necessary information.

<table>
<thead>
<tr>
<th>Information</th>
<th>CMS-1500 Line Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient name</td>
<td>2</td>
<td>Name of the patient actually receiving service</td>
</tr>
<tr>
<td>Member ID number</td>
<td>1a</td>
<td>The patient’s Oxford ID number</td>
</tr>
<tr>
<td>Date of service</td>
<td>24a</td>
<td>Date on which service was performed</td>
</tr>
<tr>
<td>Other insurance coverage</td>
<td>9a</td>
<td>Coverage in addition to Oxford</td>
</tr>
<tr>
<td>Provider name/address</td>
<td>33</td>
<td>Name/address of treating physician or provider</td>
</tr>
<tr>
<td>Provider number</td>
<td>33</td>
<td>Treating provider’s Oxford ID number</td>
</tr>
<tr>
<td>Provider FTIN</td>
<td>25</td>
<td>Federal tax ID number</td>
</tr>
<tr>
<td>Diagnosis code</td>
<td>24E</td>
<td>ICD-9-CM code(s) for the primary and secondary diagnoses for which patient is being treated</td>
</tr>
<tr>
<td>Services/procedures</td>
<td>24D</td>
<td>Service(s) itemized by CPT-4 code and/or HCPCS code and modifiers, if applicable (i.e., per service or procedure)</td>
</tr>
<tr>
<td>Number of days and units</td>
<td>24G</td>
<td>Days or units of service as appropriate; must be whole numbers</td>
</tr>
<tr>
<td>Total charge</td>
<td>28</td>
<td>Sum of all itemized charges or fees</td>
</tr>
<tr>
<td>Certain conditions</td>
<td>10</td>
<td>If a visit is related to employment or accident</td>
</tr>
</tbody>
</table>
Using the Correct Place Codes

To ensure timely and accurate payment of claims, Oxford will be using the place codes created by CMS and mandated by HIPAA for electronic transactions. In prior years, Oxford place codes and alpha-codes were accepted. All providers are now required to submit claims with the correct CMS place code. These place codes are to be used for services provided to commercial and Medicare Members. The CMS place codes include the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Office</td>
</tr>
<tr>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td>15</td>
<td>Mobile diagnostic unit</td>
</tr>
<tr>
<td>20</td>
<td>Urgent care facility</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient hospital</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient hospital</td>
</tr>
<tr>
<td>23</td>
<td>Emergency room hospital</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory surgical center</td>
</tr>
<tr>
<td>25</td>
<td>Birthing center</td>
</tr>
<tr>
<td>26</td>
<td>Military treatment facility</td>
</tr>
<tr>
<td>31</td>
<td>Skilled nursing facility</td>
</tr>
<tr>
<td>32</td>
<td>Nursing facility</td>
</tr>
<tr>
<td>33</td>
<td>Custodial care</td>
</tr>
<tr>
<td>34</td>
<td>Hospice</td>
</tr>
<tr>
<td>41</td>
<td>Ambulance — land</td>
</tr>
<tr>
<td>42</td>
<td>Ambulance — air or water</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient psychiatric facility</td>
</tr>
<tr>
<td>52</td>
<td>Psychiatric facility partial hospitalization</td>
</tr>
<tr>
<td>53</td>
<td>Community mental health center</td>
</tr>
<tr>
<td>54</td>
<td>Intermediate care facility/mentally retarded</td>
</tr>
<tr>
<td>55</td>
<td>Residential substance abuse</td>
</tr>
<tr>
<td>56</td>
<td>Psychiatric residential treatment center</td>
</tr>
<tr>
<td>61</td>
<td>Comprehensive inpatient rehabilitation facility</td>
</tr>
<tr>
<td>62</td>
<td>Comprehensive outpatient rehabilitation facility</td>
</tr>
<tr>
<td>65</td>
<td>End stage renal disease facility</td>
</tr>
<tr>
<td>71</td>
<td>State or local public health clinic</td>
</tr>
<tr>
<td>72</td>
<td>Rural health clinic</td>
</tr>
<tr>
<td>81</td>
<td>Independent lab</td>
</tr>
<tr>
<td>99</td>
<td>Other unlisted facility</td>
</tr>
</tbody>
</table>
## Claim Forms and Instructions

Detailed explanations of all required information fields on claims forms are provided on the following pages.

### Required Information for Submission of Medical Claims

<table>
<thead>
<tr>
<th>Required Information</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing FTIN</td>
<td>Federal tax identification number of individual or organization requesting claim reimbursement</td>
</tr>
<tr>
<td>Oxford Rendering Provider ID number</td>
<td>Oxford-assigned provider identification number of provider rendering services, e.g., AP999 [Note: If a provider has a participating identification number, it must be used]</td>
</tr>
<tr>
<td>a. Rendering Provider Name</td>
<td>a. First and last name of provider who performed services; do not include middle initial or MD, as it is not required</td>
</tr>
<tr>
<td>b. For Facilities Only: Name of Billing Organization</td>
<td>b. Facilities Only: Name of organization or facility requesting claim reimbursement</td>
</tr>
<tr>
<td>Billing City, State, Zip</td>
<td>City, state, and zip code of provider requesting claim reimbursement</td>
</tr>
<tr>
<td>Billing Address</td>
<td>Street address of provider requesting claim reimbursement</td>
</tr>
<tr>
<td>Patient Oxford ID number</td>
<td>Patient’s Oxford Member identification number [Do not use a space or an asterisk when entering a Member ID number, e.g., 17935801]</td>
</tr>
<tr>
<td>Patient Last Name</td>
<td>Last name of the patient</td>
</tr>
<tr>
<td>Patient First Name</td>
<td>First name of the patient</td>
</tr>
<tr>
<td>Patient Gender</td>
<td>Sex of the patient</td>
</tr>
<tr>
<td>Patient Date of Birth</td>
<td>Date of birth of the patient [Eight character spaces for date of birth, e.g., 01011957 not 010157]</td>
</tr>
<tr>
<td>CPT/HCPC Code(s)</td>
<td>The service or procedure performed, associated with charge or fee itemized by each HCPC or CPT-4 code; as appropriate, include relevant modifier</td>
</tr>
<tr>
<td>Diagnosis Code(s)</td>
<td>ICD-9-CM code[s] of primary or secondary diagnosis for which patient is being treated</td>
</tr>
<tr>
<td>Date[s] of Service</td>
<td>Date[s] on which the service was provided [‘‘From-To’’ dates will not be accepted for multiple dates of service]</td>
</tr>
<tr>
<td>Place Code[s] or Place of Service</td>
<td>Code[s] used to indicate the place where procedure was performed</td>
</tr>
<tr>
<td>Name, address of facility where services were performed</td>
<td>As appropriate — Name and address of place where services were rendered</td>
</tr>
<tr>
<td>Requested Amounts</td>
<td>Total billing amount[s] requested by provider per service line</td>
</tr>
<tr>
<td>Assignment of Benefits</td>
<td>As appropriate — Authorization for claim reimbursement to be made to billing provider</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>As appropriate — Coverage in addition to Oxford</td>
</tr>
<tr>
<td>Units of Service</td>
<td>As appropriate — Please use whole numbers</td>
</tr>
</tbody>
</table>
The following information is required for claims processing. If this information is not provided, the claim will be suspended and payment withheld until Oxford receives the necessary information.

**Box 2:** Patient Last Name, First Name, Middle Initial: Patient whose ID is referenced in Box 1a.

**Box 3:** Patient Date of Birth, Patient Sex: Date of birth and gender of patient (eight character spaces for date of birth, i.e., 01011957 or 010157).

**Box 1a:** Patient Oxford ID Number: Patient’s Oxford Member identification number. (Do not use a space or an asterisk when entering a Member ID number.)

**Box 9a:** Coordination of Benefits: As appropriate, coverage in addition to Oxford.

**Box 24a:** Date(s) of Service: Date(s) on which the service was provided (from-to dates will not be accepted for multiple dates of service).

**Box 24b:** Place code or Place of Service: Code(s) used to indicate the location of procedure performed.

**Box 24c:** CPT/HCPCS code(s): The service or procedure performed, associated with charge of fee itemized by each HCPCS or CPT-4 code.

**Box 24d:** Diagnosis Code: ICD-9-CM code(s) of primary or secondary diagnosis for which patient is being treated.

**Box 25:** Billing FTIN: Individual/organization to whom claim reimbursement is made.

**Box 33:** FOR FACILITIES ONLY: Name of Organization: Name of facility to whom claim reimbursement is made.

**Box 33:** Oxford Rendering Provider ID: Oxford-assigned identification number of rendering services, e.g., AP9999.

**Box 33:** Rendering Provider Name (First and Last), Address, Zip Code: Provider who performs services.

**Box 13:** Assignment of Benefits: Authorization for claim reimbursement to be made to billing provider.

**Box 28:** Requested Amount: Total billing amount requested by provider by service line.

**Box 24g:** Unit(s) of Service: As appropriate; must be whole numbers.

If applicable, please include all pertinent Coordination of Benefits, Assignment of Benefits, Referral, and Type of Service information.
### Required Information for Submission of Hospital/Facility Claims

<table>
<thead>
<tr>
<th>Required Information</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing FTIN</td>
<td>Federal tax identification number of the organization requesting reimbursement</td>
</tr>
<tr>
<td>Facility ID Number</td>
<td>Oxford-assigned provider identification number of the facility requesting claim reimbursement, e.g., HO1234, ANC123</td>
</tr>
<tr>
<td>Billing Facility Name</td>
<td>Name of the organization requesting claim reimbursement</td>
</tr>
<tr>
<td>Billing Facility Zip Code, City, State</td>
<td>City, state and zip code of organization requesting claim reimbursement</td>
</tr>
<tr>
<td>Billing Address</td>
<td>Street address of the organization requesting claim reimbursement</td>
</tr>
<tr>
<td>Patient Oxford ID number</td>
<td>Oxford Member identification number of person to whom services are being rendered (Do not use a space or an asterisk when entering Member ID number, e.g., 17935801)</td>
</tr>
<tr>
<td>Patient Last Name</td>
<td>Last name of the patient</td>
</tr>
<tr>
<td>Patient First Name</td>
<td>First name of the patient</td>
</tr>
<tr>
<td>Patient Gender</td>
<td>Sex of the patient</td>
</tr>
<tr>
<td>Patient Date of Birth</td>
<td>Date of birth of the patient (Eight spaces are provided for date of birth, e.g., 01011957 not 010157)</td>
</tr>
<tr>
<td>Revenue Code[s]</td>
<td>Code that identifies a specific accommodation, ancillary service or billing calculation</td>
</tr>
<tr>
<td>Diagnosis Code[s]</td>
<td>The ICD-9-CM code describing the principal diagnosis (i.e., the condition determined after study to be chiefly responsible for admitting the patient for care)</td>
</tr>
<tr>
<td>Date[s] of Service</td>
<td>Date[s] on which service was performed (&quot;From-To&quot; dates are accepted for inpatient charges only; outpatient charges must be entered line-by-line for each date-of-service)</td>
</tr>
<tr>
<td>Place Code[s] or Place of Service</td>
<td>Code[s] used to indicate the place where procedure was performed</td>
</tr>
<tr>
<td>Requested Amounts</td>
<td>Total billing amount requested by the provider</td>
</tr>
<tr>
<td>CPT/HCPC Code[s]</td>
<td>The charge or fee for the service itemized by each HCPC or CPT-4 code, e.g., per service or procedure; inpatient charges do not require CPT codes; outpatient charges require CPT codes</td>
</tr>
<tr>
<td>Units of Service</td>
<td>As appropriate — A quantitative measure of services rendered by revenue category to or for the patient, to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc.</td>
</tr>
<tr>
<td>Condition Code[s]</td>
<td>As appropriate — Code[s] used to identify relating conditions that may affect Oxford's processing</td>
</tr>
<tr>
<td>Occurrence Code[s]</td>
<td>As appropriate — Hospital/Facility codes and associated dates defining a significant event relating to this bill that may affect Oxford's processing</td>
</tr>
<tr>
<td>Occurrence Span Code[s]</td>
<td>As appropriate — Hospital/Facility codes and the related dates that identify an event that relates to the payment of the claim</td>
</tr>
</tbody>
</table>
### Required Information for Submission of Hospital/Facility Claims (continued)

<table>
<thead>
<tr>
<th>Required Information</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assignment of Benefits</td>
<td><strong>As appropriate</strong> — Authorization for claim reimbursement to be made to billing provider</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td><strong>As appropriate</strong> — Coverage in addition to Oxford</td>
</tr>
<tr>
<td>Statement Covers Date</td>
<td>The beginning and ending service dates of the period included on this claim</td>
</tr>
<tr>
<td>Covered Days</td>
<td>The number of days covered by the primary insurer, as qualified by that organization</td>
</tr>
<tr>
<td>Non-covered Days</td>
<td>Days of care not covered by the primary insurer</td>
</tr>
<tr>
<td>Coinsurance Days</td>
<td>The inpatient Medicare days occurring after the 60th day and before the 91st day, or inpatient skilled nursing facility (SNF) swing bed days occurring after the 20th and before the 101st day in a single period of illness</td>
</tr>
<tr>
<td>Lifetime Reserve Days</td>
<td>Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a period of illness</td>
</tr>
<tr>
<td>Patient Marital Status</td>
<td>The marital status of the patient at date of admission, outpatient service or start of care</td>
</tr>
<tr>
<td>Admission/Start of Care Date</td>
<td>The date the patient was admitted to the provider of inpatient care, outpatient service or start of care</td>
</tr>
<tr>
<td>Admission Hour</td>
<td>The hour during which the patient was admitted for inpatient or outpatient care</td>
</tr>
<tr>
<td>Admission Type</td>
<td>Hospital/Facility code indicating the priority of this admission</td>
</tr>
<tr>
<td>Admission Source</td>
<td>Hospital/Facility code indicating the source of this admission</td>
</tr>
<tr>
<td>Discharge Hour</td>
<td>Hour that the patient was discharged from inpatient care</td>
</tr>
<tr>
<td>Patient (discharge) Status</td>
<td>Hospital/Facility code indicating patient status as of the ending service date of the period covered on this bill, as reported in field 6 of the form</td>
</tr>
<tr>
<td>Medical/Health Record Number</td>
<td>The number assigned to the patient’s medical/health record by the provider</td>
</tr>
<tr>
<td>Treatment Authorization Codes</td>
<td>A number, Hospital/Facility code, or other indicator that designates that the treatment covered by this bill has been authorized by Oxford</td>
</tr>
<tr>
<td>Admitting Diagnosis Code</td>
<td>The ICD-9-CM diagnosis code provided at the time of admission, as stated by the physician</td>
</tr>
<tr>
<td>External Cause of Injury Code or (E-code)</td>
<td>The ICD-9-CM code for the external cause of an injury, poisoning adverse effect</td>
</tr>
</tbody>
</table>

---

If you require assistance entering provider or patient information while completing a claim form, please call your software vendor or call Oxford’s Provider eSolutions Support Team at **1-800-599-4334**.
Billing

Requirements for Inpatient and Outpatient Billing

Remember, all claims must be submitted within 90 days of completed services or payment for that service may be reduced or denied.

In addition:

- Claims must be submitted electronically or on a completed CMS-1500 or UB-92 form
- Claims must be submitted with the appropriate CPT codes as established by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) as established by the Centers for Medicare and Medicaid Services (CMS)
- The Health Insurance Portability and Accountability Act (HIPAA) transaction and code set rule requires usage of the medical code set that is valid at the time that the service is provided; CMS will no longer permit a 90-day grace period to use discontinued codes for services rendered in the first 90 days of the year; to help promote prompt and timely payment of claims, the new CPT/HCPCS codes rendered must be used for services beginning on or after January 1 of each year

Balance Billing Policy

Providers in Oxford’s network may not bill Members for unpaid charges above their specific Member cost sharing (i.e., copayment, deductible, coinsurance excess or charges over UCR), except when services are determined by Oxford to be non-covered services (i.e., services that are excluded from coverage in the “Exclusions and Limitations” section of the Member’s Certificate of Coverage/Evidence of Coverage and for which the Member is responsible for payment, or services incurred when the Member was not eligible for Oxford coverage) or when the Member has exceeded or exhausted a benefit limit.

If you are uncertain whether a service is covered, you must make reasonable efforts to contact Oxford and obtain coverage determination before seeking payment from an Oxford Member. Oxford’s network providers may not bill a Member for:

- Any difference between Oxford’s payment to you for a covered service and your billed charges
- The entire amount or partial amount of a claim that was denied by Oxford because you failed to obtain a required precertification or an Oxford referral for those plans that require a referral

Exception: Commercial Freedom Plan® and Liberty Plan Members may access specialist services on an out-of-network basis without a referral. In such cases, plan Members may be billed for deductible and coinsurance amounts by you. However, you may not bill the Member for any difference between your billed charges and Oxford’s fee schedule.

- The entire amount or partial amount of a claim that was denied by Oxford solely because the service was determined to be not medically necessary
• Any line item in a claim for covered services that was included in, or excluded from, a more comprehensive payment code in accordance with Oxford’s claims processing procedures

• Any line item that is adjusted in accordance with a reimbursement policy

• Fees for all or part of covered services before services are rendered (except for applicable copayments, coinsurance, and deductibles)

• Administrative services (e.g., faxing, mailing referrals, completing forms, or other standard office functions)

Remember, in those cases that require a referral, if you perform the service without a referral, the claim will be denied or paid out-of-network based on your contracted rate. In accordance with your Oxford Agreement, the Member is held harmless, and you cannot balance bill the Member except for possible deductible and coinsurance, dependent upon Member’s benefit. Providers in Oxford’s network who repeatedly violate these restrictions for billing Members will be subject to discipline, which may include termination of your provider agreement.

Any notices to Members that advise them that a bill has been forwarded to Oxford must clearly state that no money is due.

When submitting an address change form or tax ID change, you must include the following:

• A completed Oxford Address Change Form or a letter on your provider letterhead

• A signed W-9 form [needed for tax ID changes only]

When submitting changes on your provider letterhead, you must include the following:

• A description of the change (new or additional address, telephone number or tax ID number change)

• The old and the new billing address

• The old and the new practice address

• Phone number change [if applicable]

• The tax ID number and your Oxford provider ID number

• The effective date of change

All documentation should be mailed or faxed to the following address:

Oxford Health Plans
Attention: Vendor Audit
48 Monroe Turnpike
Trumbull, CT 06611
or Fax: 203-459-7367

It’s easy to change your practice address electronically; log in to your personalized provider home page at www.oxfordhealth.com and click on change address.

The W-9 and Address Change forms are available online at www.oxfordhealth.com or by calling Oxford’s Provider Services Department at 1-800-666-1353.
Coordination of Benefits (COB)

Before you can submit a claim for processing, you must first determine if Oxford is the only health plan involved. Coordination of benefits (COB) is the process which determines the order of payment of health insurance coverage when more than one group plan is involved.

By coordinating the benefits of the different plans, Oxford can determine which insurance has primary responsibility for a claim and which should pay the balance of any remaining covered expenses, up to the maximum benefit.

When Oxford is secondary (tertiary), normal requirements for precertification and referrals are waived, deferring to the primary carrier’s requirements. Other requirements are not waived (e.g., itemized bills, student verification, consent for Behavioral Health exchange, etc.).

Coordination of Benefits — Commercial

When a patient’s secondary coverage is Oxford, you should bill the primary insurance company. When you receive the primary insurance company’s explanation of benefits, submit it to Oxford with the pertinent claim information, and we will apply benefits as the secondary carrier, up to the limits of coverage under the Member’s plan.

If the information in Oxford’s file does not coincide with the COB information on the claim submitted, Oxford will proceed accordingly:

• If Oxford has not received COB information from the Member in the last 12 months and the claim lists another carrier’s name, Oxford will call the carrier within 24 hours to validate the information and then release the claims for processing; if the Member’s COB can be validated with the other insurance carrier, the claim will be released for processing; if it cannot be validated, the claim will be automatically pended, and the provider will be notified of the claim’s suspended status

• If Oxford has not received COB information from the Member in the last 12 months, and COB is indicated on the claim form, but the

name of the insurance carrier is not included, a COB questionnaire will be sent to the Member for the requested information and the claim will be processed accordingly

• If the claim indicates COB and involves a possible workers’ compensation or motor vehicle accident, Oxford will contact the carrier and/or Member to validate the information and the claim is released for processing; if the information cannot be validated, the primary insurance claim will be automatically pended; notice of the claim’s suspended status is given to the provider; additional workers’ compensation or motor vehicle claims received will be processed accordingly

Claims fitting the descriptions above can be suspended for up to 30 days. If the Member does not respond to the COB Department within the 30-day period, the claim will be denied in Oxford’s system. If the COB Department receives a response within the 30-day period, the Member’s file will be updated, and the claim will be released for processing.

Coordination of Benefits Birthday Rule — Commercial Dependents

The “birthday rule” applies to dependent children covered by both parents’ carriers. The “birthday rule” states that the coverage of the parent whose birthday falls first in the calendar year (not necessarily the parent who is older) is the primary carrier for the dependent(s).

For example:

• If the mother’s birthday is February 27 and she is a Member of a health insurance policy other than Oxford, and the father’s birthday is April 2, and he is an Oxford Member, the children and mother are covered first under the mother’s policy (non-Oxford); Oxford is the children and the mother’s secondary carrier; in this scenario, Oxford pays first for the father, but second for the rest of the family

• If both parents have the same birth date, then the primary coverage is the coverage that has been in place longer
Coordination of Benefits — MedicareComplete® Plans and Evercare Plan DH

Oxford will coordinate benefits for Members who are Medicare beneficiaries according to federal Medicare program guidelines. Generally, coordination is necessary in two situations:

1) The Oxford commercial Member is also a Medicare beneficiary

In this case, Oxford has primary responsibility if the Member is:

• 65 or older, and his or her Oxford coverage is sponsored by an employer with 20 or more employees

• Disabled, and his or her Oxford coverage is sponsored by an employer with 100 or more employees

• Eligible for Medicare due to end stage renal disease (ESRD) and enrolled in an Oxford commercial plan (Oxford's primary responsibility lasts 33 months for beneficiaries with ESRD)

2) A MedicareComplete® or Evercare Plan DH Member who has coverage through a group plan with another insurer

In this case, a Member has agreed to receive his or her Medicare benefits through SecureHorizons® | Oxford, and in SecureHorizons | Oxford's capacity as a Medicare contractor, the plan has a primary responsibility when the Medicare plan would be primary and secondary responsibility when Medicare would be secondary (such as those situations previously described regarding the Oxford commercial Member).

Other Information for Coordination of Benefits

• Oxford has the right to release information to another organization or obtain information from another organization in order to coordinate benefits

• If Oxford has paid more than the maximum required under the plan, we may recover the excess amount from anyone to whom the excess payments were made or from any other insurance company or organization

Provider Reimbursement

Commercial Products

PCP/Specialist Reimbursement — When joining Oxford, all PCPs and specialists agree to accept Oxford’s fee schedule and the payment and processing policies associated with the administration of these fee schedules. All fees paid by Oxford, together with the patient’s copayment, deductible and/or coinsurance (if applicable), are to be accepted as payment in full. Providers must not balance bill Members for in-network covered services. If providers fail to precertify services, they may not balance bill the Member.

Hospital Reimbursement — Oxford will reimburse hospitals for services provided to Members at the rates established in the fee schedule or in schedule or attachment of the hospital contract. Payment rates shall include payment for all professional services by a providers covered by a hospital’s tax identification number or who have a principal practice location at the hospital’s address. All fees paid by Oxford, together with the patient’s copayment, deductible and/or coinsurance (if applicable), are to be accepted as payment in full.

Ancillary Facility Reimbursement — Oxford will reimburse ancillary providers for services provided to Members at the rates established in the fee schedule or in attachment or schedule of the ancillary contract. Providers must not balance bill Members for in-network covered services. If providers fail to precertify services, they may not balance bill the Member.
Section 8 — Claims, Billing and Provider Reimbursement

**MedicareComplete® Plans and Evercare Plan DH**

PCP Reimbursement — If you receive fee-for-service reimbursement from Oxford for services provided to Medicare Members, you must submit claims to Oxford electronically or on a CMS-1500 form. You will be reimbursed at agreed-upon rates, less the applicable Medicare Member copayment/out-of-pocket cost. If you are a capitated PCP, you must submit claims to Oxford as if under a traditional fee-for-service billing arrangement.

Specialist Reimbursement — Medicare Members should pay the appropriate copayment/out-of-pocket cost to the specialist when applicable. The specialist bills Oxford directly. Oxford will reimburse at agreed-upon rates. Providers should not bill federal Medicare.

Hospital/Facility Reimbursement — The provider must precertify services or must submit an electronic referral if applicable, in accordance with Oxford’s policies for hospitals and facility services. See section 4 on Precertification for more information.

The Medicare Member may be responsible for a copayment/out-of-pocket cost. The facility bills Oxford directly. Oxford will reimburse at agreed-upon contracted rates. Do not bill federal Medicare; you will not be reimbursed, and it may delay your payment.

**General Reimbursement Guidelines**

Oxford reimburses claims for medically necessary covered services in accordance with Oxford’s medical and administrative policies and the contracted fee schedule that is applicable to the Oxford network in which you participate, and the Member’s copayment, deductible and coinsurance, where applicable. The following is a list of commonly requested administrative policies related to reimbursement of claims. All of these policies are available on www.oxfordhealth.com and can be accessed by authenticated providers (i.e., a user ID and password is required to view the documents) via the Tools & Resources tab under Practical Resources > Medical & Administrative Policies.

Please note: Oxford’s medical and administrative policies are subject to change. A monthly policy update bulletin is posted on www.oxfordhealth.com on the first business day of each month. By accessing this communication, you may view a list of recently approved and revised policies, in their entirety, 30 days prior to their implementation date.

- Add On Codes
- After Hours and Weekend Care
- Assistants at Surgery (Assistant Surgeon)
- Bilateral Surgery
- Contrast Agents for Radiology Procedures
- Co-surgeons/Team Surgery
- Distinct Procedural Service (Modifier -59)
- Evaluation and Management Codes
- Global Surgical Package
- Maximum Frequency
- Modifier 25
- Modifiers 54, 55, 56
- Modifiers
- Multiple Imaging Rules
- Multiple Surgery
- Obstetrical Care
- Obstetrical Ultrasonography
- Oxford’s In-office Laboratory Testing and Procedures List
- Oxford’s Radiology Privileging List
- Prolonged Services
- Radiology Procedures for CareCore National Arrangement
• Radiology Procedures Requiring Precertification
• Reduced Services
• Reimbursement for Comprehensive and Component CPT Codes
• Same Day/Same Service
• Surgical Care Including Preoperative and Postoperative Mgmt (Mod 54, 55, 56)
• Technical Component and Professional Component (TC/PC)
• Telephone Calls, E-mail and other Non-personal Communications
• Therapeutic and Diagnostic Injection Policy
• Unusual Services
• Vision Services

Correct Coding and IntelliClaim System

All claims submitted to Oxford must be correctly coded using the appropriate CPT code(s) or HCPCS code(s). According to the American Medical Association, Healthcare Common Procedure Coding System (HCPCS), when both a CPT and a HCPCS Level II code have virtually identical narratives for a procedure or service, the CPT code should be used. If, however, the narratives are not identical, the Level II HCPCS code should be used.

As set forth in Oxford's current Reimbursement Methodology for Comprehensive and Component Codes policy, the process of assigning a code to a procedure or service depends on both the procedure performed and the documentation that supports it. When multiple procedures are performed on a patient during a single session or visit, the claim is submitted with multiple codes instead of one comprehensive code that fully describes the entire service, Oxford will reimburse the claim based upon the comprehensive procedure and adjust the separately billed component, incidental or mutually exclusive procedures that were performed during the same session. If a claim is incorrectly coded, Oxford, through its claims system, will correct the coding error by adding a new claim line with the correct comprehensive code.

To rebundle a claim, Oxford's claims system utilizes a software package assembled by IntelliClaim (owned by McKesson Health Solutions). IntelliClaim's product provides a platform on which two off-the-shelf and widely-used products (referenced below) are combined with a flexible environment that allows Oxford to develop, customize and update our payment guidelines as necessary. The efficiency, accuracy and speed with which edits can be applied, the detailed documentation supporting the logic behind the rules, and the clear explanations for claim adjustments result in more automated claim processing as well as quick turnaround. As part of the IntelliClaim package, IntelliClaim has incorporated two software packages to rebundle codes. These software packages are the Correct Coding Initiative Software by The National Technical Information Service (NTIS) and ClaimsXten™ by McKesson.

The NTIS software provides Oxford with the Correct Coding Rules used by The Centers for Medicare and Medicaid Services (CMS). This software is the same software product used by fiscal intermediaries that process Medicare Fee for Service claims for CMS. The Correct Coding Rules can be found on CMS's web site at www.cms.hhs.gov. The IntelliClaim software incorporates the quarterly updates that CMS makes to the Correct Coding rules into Oxford's claims processing system. ClaimsXten™ contains KnowledgePacks consisting of rules that, among other things, characterize coding relationships on provider medical bills. ClaimsXten™ provides information that allows claims submitters, claims processors and adjudicators to identify potentially incorrect or inappropriate coding relationships by a single provider, for a single patient, on a single date of service. Examples of the rules include incidental, mutually exclusive, unbundling and visit edits. Sources of the KnowledgePacks include the AMA and CPT publications, CMS, specialty societies, and McKesson physician consultants.
Senior Oxford Medical Directors will review certain categories of code pairs encompassed in the McKesson KnowledgePacks, which are not currently implemented in Oxford’s system. In certain clinical circumstances, the Medical Directors may deem that certain code pairs should deviate from the default rules for comprehensive procedures. The implementation of ClaimsXten™ is scheduled to be phased in as the review is completed. In light of the changes to Oxford’s policy on modifiers -25 and -59 (effective December 1, 2005), future updates to the NTIS and ClaimsXten™ software may be installed without review by Oxford’s Medical Directors and will follow Oxford’s regular update schedule.

Please be aware that this reimbursement policy is subject to Oxford’s reimbursement policies and rules including, but not limited to the following Oxford policies:

- Modifiers
- Modifier -25
- Global Surgical Package
- Distinct Procedural Services [Modifier -59]

Please note: Information about Correct Coding Rules can be found on the CMS web site at http://www.cms.hhs.gov/physicians/cciedits/.

Modifiers

Oxford only recognizes the use of modifiers under the specific circumstances listed in our administrative policies (which are available on our web site). Oxford will reimburse correctly coded claims with modifiers only as indicated in these policies, including after a review of clinical notes. All other uses of modifiers will not be reimbursed.

Evaluation and Management on Same Day as Surgery

When you perform an established evaluation and management (E&M) or inpatient/outpatient consultation procedure on the same day a surgical procedure is performed, the reimbursement for the E&M procedure will be included in the fee for the surgical procedure. The fee for certain supplies associated with the procedure is also included in the reimbursement for the surgical procedure. The list of surgical procedures that we consider exempt is located in the global surgical package policy. In addition, refer to the modifier -25 policy for additional information on E&M codes and same day surgery.

Multiple Surgical Procedures Performed During Same Operative Session

Oxford utilizes the CMS multiple procedure indicators 1, 2 and 3 as set forth in the NPFS relative value file to determine which procedures are eligible for multiple procedure reductions.

When you perform two or more surgical procedures during the same operative session, for reimbursement purposes, we will consider the procedure with the highest CMS-based relative value unit the primary procedure. All other procedures performed during the operative session are multiple procedures and should be billed with a multiple surgery modifier (-51). A secondary procedure that is not billed with the -51 modifier will be adjusted, and an identical new claim line(s) will be added with a -51 modifier appended to the code. The fee for these secondary procedures will be 50 percent of the fee schedule amount. This policy does not apply if the surgical procedure is considered exempt according to the most current CPT Code Book list of procedures exempt from modifier-51 payment rules.
Global Surgical Package (GSP)

A global period for surgical procedures is a long-established concept under which a “single fee” is billed and paid for all services furnished by a surgeon before, during and after the procedure. According to CMS, the services included in the GSP may be furnished in any setting (e.g., hospital, ambulatory surgery center, physician’s office).

Oxford’s GSP policy applies the CMS time frames assigned to each global surgical procedure. All procedures with an entry of 1, 10, 90, or MMM days in the Medicare Fee Schedule Database (MFSDB) are subject to Oxford’s GSP Policy.

Under the GSP policy, the fee for any evaluation and management procedure performed within the follow-up period is included in the reimbursement for the surgical procedure. The fee for certain supplies associated with the procedure is also included in the reimbursement for the global surgical procedure if used within the follow-up period. If you bill for such supplies and services separately, we will indicate on the claim that such services are inclusive and reimburse for the global surgical code.

Please note: The modifiers may only override the GSP time frames as authorized by and under the specific circumstances listed in our policies on modifiers.

Correct Coding of Office Visits and Consultations

When you bill for a new patient office visit, outpatient visit, preventive E&M, or ophthalmology visit, the patient’s claims history will be checked to determine if the patient has been seen by you or your provider group within the last three (3) years. In accordance with the 2005 CPT code guidelines, if the patient has been seen within the last three (3) years, the claim line on which the new patient E&M code appears will be adjusted, and an identical new claim line will be added with an established E&M visit code, at the same level as the new patient code that was billed.

Availability of Policies and Fees

To obtain a copy of Oxford’s administrative and medical policies, please send a written request specifying the issue, codes or procedures to:

Oxford Health Plans
Attention: Policy Requests and Information
48 Monroe Turnpike
Trumbull, CT 06611

All of Oxford’s clinical policies, in addition to some commonly requested administrative and reimbursement policies, are posted on www.oxfordhealth.com and can be accessed by any web site user. [A username and password are not required to view the documents]. These policies can be viewed under the Get to Know Oxford section of the home page. Web site users may access the documents by clicking on one of the multiple links located at the bottom of the page and viewing Medical & Administrative Policies > Policy Index from the selected reference page.

In addition, all of Oxford’s clinical, administrative, and reimbursement policies are available on www.oxfordhealth.com and can be accessed by authenticated providers (i.e., a user ID and password is required to view the documents) via the Tools & Resources tab under Practical Resources > Medical & Administrative Policies.

Although Oxford’s entire fee schedule is proprietary and cannot be distributed, we will, upon request, provide our current fees for the top codes billed by you. Fees are adjusted periodically, and we will use our reasonable efforts to notify you of fee changes applicable to your practice. Our Provider Services Department is available to provide this information and to answer questions regarding claims payment.
To request information regarding our fees, please call our Provider Services Department at 1-800-666-1353.

**Notice of Changes or Revisions to Oxford Medical and Administrative Policies**

A monthly policy update notice is posted on [www.oxfordhealth.com](http://www.oxfordhealth.com) on the first business day of each month. By accessing one of the following communications, customers may now view recently approved and revised policies, in their entirety, 30 days prior to their implementation date.

**Medical and Administrative Policy Update Bulletin**

Authenticated providers and facilities may reference the monthly policy update bulletin containing a link to all recently approved or revised administrative, clinical and reimbursement policies, 30 days prior to their implementation date. This communication may be accessed by authenticated web site users via the Tools and Resources tab under **Practical Resources > Medical & Administrative Policies > Policy Update Bulletin.**

**Clinical Policy Update Bulletin**

All customers may reference the monthly clinical policy update bulletin containing a link to recently approved or revised clinical policies only, 30 days prior to their implementation date. This bulletin may be accessed via the home page under **Get to Know Oxford > Medical & Administrative Policies > Policy Update Bulletin.**

We will continue to provide notice of all policy changes in the quarterly **Provider Program and Policy Update (PPU);** however, the effective date for policy changes will be based upon the date the change is published on our web site.