Applicable To:
- ☑ Medicare
- ☑ Medicaid – excluding AZ, FL, KY, and NC

Claims and Payment Policy: Maximum Units for Reimbursement

Policy Number: CPP- 111

Original Effective Date: 09/17/2015

Revised Date(s): 10/10/2017, 2/1/2018, 4/27/2018, 4/4/2019, 3/26/2020

BACKGROUND

Frequent billing errors are made when assigning the number of units to a procedure code. For example, the units for a drug may be mistakenly billed as the number of milligrams, e.g., 50, where the actual unit of service may be 1 (1 unit = 50mg), or the descriptor for a CPT code may specify "bilateral" meaning the code includes both sides of the body, and the maximum units that may be billed is 1, not 2. Maximum units edits are unit-of-service claim edits applied to medical claims against a procedure code for medical services rendered by 1 provider/supplier to 1 patient for a period of time, usually 1 day. These claim edits compare different values on medical claims to a set of defined criteria to check for irregularities. Maximum units edits are designed to limit fraud or coding errors. They represent an upper limit that unquestionably requires further documentation to support.

Per CMS, Medically Unlikely Edits (MUEs) prevent payment for a potentially inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) reportable under most circumstances by the same provider for the same beneficiary on the same date of service. The ideal MUE value for a HCPCS/CPT code is one that allows the vast majority of appropriately coded claims to pass the MUE.

Medically Unlikely Edits (MUEs) are used by the Medicare Administrative Contractors (MACs), including Durable Medical Equipment (DME) MACs, to reduce the improper payment rate for Part B claims. A MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. Not all HCPCS/CPT codes have a MUE.

POSITION STATEMENT

The purpose of this policy is to define payment criteria for the maximum units of service billed on a claim to be used by Wellcare in making payment decisions and administering benefits per CMS and AMA CPT coding guidelines. This policy applies to any provider submitting claims for procedure codes for which maximum units limits have been exceeded. The ideal maximum unit value for a HCPCS/CPT code that allows the vast majority of appropriately coded claims to bypass editing. Claim lines exceeding the maximum allowable units are denied.

This policy includes, but is not limited to, CMS's Medically Unlikely Edits (MUE). For most CPT/HCPCS codes, these edits dictate the maximum units of service (UOS), under most circumstances, allowable for the same provider for the same beneficiary on the same calendar date of service, over a specified period of time or over a beneficiary's lifetime. This policy applies to all professional and outpatient facility claims coded with a CPT or HCPCS code. The maximum units' value applies regardless of whether or not the code is reported on one line, multiple lines or multiple claims.

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The use of CPT/HCPCS modifiers (e.g. 76, 77, 91, anatomic) may or may not impact the number of units allowed. **State Medicaid agencies or fiscal agents may have rules limiting use of these modifiers with some HCPCS/CPT codes.**

MUE Criteria

The maximum units value for each HCPCS/CPT code is based on one or more of the following criteria:

1. Anatomic considerations may limit units of service based on anatomic structures. For example, the MUE value for an appendectomy is one since there is only one appendix.

2. The CPT code descriptors or CPT coding instructions in the CPT Manual may limit units of service.

3. Nationally recognized sources such as CMS, NCCI, or specialty society guidelines.

4. The nature of a procedure/service may limit units of service and is in general determined by the amount of time required to perform a procedure/service (e.g., overnight sleep studies) or clinical application of a procedure/service (e.g., motion analysis tests).

5. The nature of equipment may limit units of service and is in general determined by the number of items of equipment that would be utilized (e.g., cochlear implant or wheelchair).

6. Fee schedules, provider manuals, bulletins or contracts.

7. Prescribing and FDA guidelines.

Limitations

A physician shall not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes these services. For example, if a physician performs a vaginal hysterectomy on a uterus weighing less than 250 grams with bilateral salpingo-oophorectomy, the physician shall report CPT code 58262 (Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)). The physician shall not report CPT code 58260 (Vaginal hysterectomy, for uterus 250 g or less ;) plus CPT code 58720 (Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)).

A physician shall not fragment a procedure into component parts. For example, if a physician performs an anal endoscopy with biopsy, the physician shall report CPT code 46606 (Anoscopy; with biopsy, single or multiple). It is improper to unbundle this procedure and report CPT code 46600 (Anoscopy; diagnostic,...) plus CPT code 45100 (Biopsy of anorectal wall, anal approach...). The latter code is not intended to be used with an endoscopic procedure code.

A physician shall not unbundle a bilateral procedure code into two unilateral procedure codes. For example, if a physician performs bilateral mammography, the physician shall report CPT code 77066 (Diagnostic mammography... bilateral). The physician shall not report CPT code 77065 (Diagnostic mammography**...** unilateral) with two UOS or 77065LT plus 77065RT.

A physician shall not unbundle services that are integral to a more comprehensive procedure. For example, surgical access is integral to a surgical procedure. A physician shall not report CPT code 49000 (Exploratory laparotomy,...) when performing an open abdominal procedure such as a total abdominal colectomy (e.g., CPT code 44150).

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Physicians must avoid downcoding. If a HCPCS/CPT code exists that describes the services performed, the physician must report this code rather than report a less comprehensive code with other codes describing the services not included in the less comprehensive code. For example, if a physician performs a unilateral partial mastectomy with axillary lymphadenectomy, the provider shall report CPT code 19302 (Mastectomy, partial...; with axillary lymphadenectomy). A physician shall not report CPT code 19301 (Mastectomy, partial...) plus CPT code 38745 (Axillary lymphadenectomy; complete).

Physicians must report UOS correctly. Each HCPCS/CPT code has a defined unit of service for reporting purposes. A physician shall not report UOS for a HCPCS/CPT code using a criterion that differs from the code's defined unit of service. For example, some therapy codes are reported in fifteen minute increments (e.g., CPT codes 97110-97124). Others are reported per session (e.g., CPT codes 92507, 92508). A physician shall not report a per session code using fifteen minute increments. CPT code 92507 or 92508 should be reported with one unit of service on a single date of service.

MUE and NCCI PTP edits are based on services provided by the same physician to the same beneficiary on the same date of service. Physicians shall not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.

A denial of services due to a maximum unit is a coding denial, not a medical necessity denial.

If a provider encounters a code with frequent denials due to the maximum units the provider should consider the following:

(1) Is the HCPCS/CPT code being used correctly?

(2) Is there a HCPCS/CPT code that more accurately reflects the services rendered?

(3) Is the unit of service being counted and reported correctly?

Additional Maximum Units Edits

Anatomical modifiers E1-E4 (eyes), FA-F9 (fingers), and TA-T9 (toes) have a maximum allowable of 1 unit per anatomical site for a given date of service. Any service billed with an anatomical modifier for more than 1 unit of service will be adjusted accordingly.
Certain obstetrical diagnostic services may have assigned maximum units per day limits based upon presence or absence of diagnosis codes indicative of multiple gestation. Units billed in excess of the maximum units per day limits will be denied.

State Exceptions

Some state Medicaid agencies or fiscal agents allow providers to report repetitive services performed over a range of dates on a single line of a claim with multiple units of service. If a provider reports services in this fashion, the provider should report the "from date" and "to date" on the claim line. Contractors are instructed to divide the units of service reported on the claim line by the number of days in the date span and round to the nearest whole number. This number is compared to the maximum unit value for the code on the claim line.

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Since maximum units are coding edits rather than medical necessity edits, state Medicaid agencies or fiscal agents may have units of service edits that are more restrictive than maximum units. In such cases, these more restrictive edits would be applied to the claim.

Documentation Requirements

In the unusual clinical circumstance when the number of units billed on the claim legitimately exceeds the assigned maximum number for that procedure, clinical documentation of the number of units actually performed should be submitted for reconsideration of the denial.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy. If State policies **do not specify coverage provisions**, then the State will follow National coverage guidelines as outlined in this policy

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

CODING & BILLING

All applicable CPT and HCPCS codes.

REFERENCES

1. Centers for Medicare and Medicaid Services. Chapter 1, General Correct Coding Policies. In: *National Correct Coding Initiative Policy Manual for Medicaid Services.* Revised January 1, 2019. Available at https://www.medicaid.gov/medicaid/program-integrity/ncci/reference-documents/index.html. Accessed March 26, 2020.
2. NCCI PTP.:https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
3. NCCI MUE: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html
4. Medicaid NCCI: https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.

The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.

References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.wellcare.com.

RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
10/30/2019	• Approved by RGC