MAXIMUM UNITS OF SERVICE

File Name: maximum_units_of_service_edits
Origination: 2/2012
Last Review: 6/2023
Next Review: 12/2023

Description

The Centers for Medicare and Medicaid Services (CMS) established units of service edits as part of the National Correct Coding Initiative (NCCI) to address coding methodologies and reduce the paid claims error rate.

A Medically Unlikely Edit (MUE) is a Medicare unit of service claim edit applied to medical claims against a procedure code for medical services rendered by one provider/supplier to one patient on one day. Claim edits compare different values on medical claims to a set of defined criteria to check for irregularities, often in an automated claims processing system. MUE are designed to limit fraud and/or coding errors. They represent an upper limit that unquestionably requires further documentation to support. The ideal MUE is the maximum unit of service for a code on the majority of medical claims. The NCCI policies are based on coding conventions by nationally recognized organizations and are updated annually or quarterly. Not all HCPCS/CPT codes have an MUE assigned by CMS.

The Maximum Units of Service policy is based upon interpretations from several standard sources: CMS, AMA CPT® (American Medical Association Current Procedural Terminology), knowledge of anatomy, medical specialty society guidelines, FDA (U.S. Food and Drug Administration) and other nationally recognized drug references, and outlier claims data from provider billing patterns. This policy has been reviewed by an expert panel of physicians with extensive clinical and coding experience.

Policy

Blue Cross Blue Shield North Carolina (Blue Cross NC) will not reimburse claims with units that exceed the assigned maximum for that service. The total number of units will be adjusted to the maximum and the excess units will be denied.

Reimbursement Guidelines

Service codes have been assigned a maximum number of units that may be billed for a member, regardless of the provider. When a provider bills a number of units that exceeds the assigned allowable unit(s) for that service, the excess units will be denied.

Laboratory service claims with units that exceed the assigned maximum will not be reimbursed. If a lab service code that is assigned a maximum unit value is reported with a greater unit count, the entire claims line will be denied, and the provider will be responsible for resubmitting the claim only for the number of units up to but not exceeding the allowed maximum. Claim line denial requiring resubmission is only applicable to laboratory services.

Drug codes have been assigned a maximum number of units that may be billed for a member. These assigned maximum units are based on maximum dosages specific to individual products, and in some instances, may also be specific to disease state. Maximum dosages utilized may be derived from industry standard resources that include, but are not limited to CMS, FDA approved product labeling, acceptable nationally recognized medical compendia, and/or other peer reviewed literature. Units billed in excess of the maximum will be denied.

Some procedure codes have been assigned a maximum number of units that may be billed over a period of time for a member, such as within a calendar year. Those services would not be done more than once within a calendar year, or twice a year for bilateral procedures. If a provider bills a number of units that exceed the assigned allowable unit(s) for a period of time for that procedure for a member, the excess units will be denied.

FIT testing reimbursement is limited to once per year.

Anatomical modifiers E1-E4 (Eyes), FA-F9 (Fingers), and TA-T9 (Toes) have a maximum allowable of one unit per anatomical site for a given date of service. Any service billed with an anatomical modifier for more than one 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 per day limits will be denied.

Team surgery and co-surgery maximums are handled separately and may be edited at the member level. When the same provider bills a number of units of team surgery or co-surgery that exceed the daily assigned allowable unit(s) for that procedure for the same member, the excess units will be denied.

Daily maximum unit thresholds have been established for those surgeries that may require the use of more than one assistant at surgery. Units billed in excess of those limits will not be eligible for reimbursement regardless of being billed by the same or different providers.

In alignment with coding guidance and CMS, there are certain codes that only allow billing of one unit per day. Adding distinct service modifiers will not bypass these unit limits. Should claim(s) be received with more than one unit on the same date of service, the additional units will not be eligible for reimbursement.

Ambulance mileage codes are distinctly different than all other codes in that they are allowed to be billed with partial or fractional units. In alignment with CMS policy, no other codes will be eligible for reimbursement when billed with partial or fractional units.

Each claim line is adjudicated separately against the maximal units of the code on that line.

Specific Unit Limits (not an all-inclusive list):

Reimbursement of:

- Ocular photography of an eye segment will be limited to no more than twice per year.
- Whole body integumentary photography is only reimbursable for high-risk members and will be limited to no more than once per year.
- Chiropractic manipulative treatment (CPT® 98940-98942) will be limited to one unit per day.
- Percutaneous implantation of a peripheral nerve neurostimulator will be limited to two units per year.

- Psychiatric diagnostic evaluations (CPT® 90791 and 90792 or any combination thereof) are limited to no more than three units per year.
- Home health agency recertification code will be limited to no more than once every 60 days.
- Diagnostic and therapeutic paravertebral facet joint injections are limited to eight times per region in a year.
- Diagnostic and therapeutic epidural or subarachnoid injections are limited to six times a year.
- Up to eight transforaminal epidural injection sessions per region may be performed in a year
    - Up to two diagnostic and up to six therapeutic
- Autonomic Nervous System (ANS) Function Testing (CPT® 95921 – 95924) is limited to one per year.

Allergy Management Services
Per unit reimbursement for allergy immunotherapy is based on the number of dosages prepared and intended for administration. Allergy immunotherapy is limited to 180 units for the first year of therapy during escalation, and 120 units for yearly maintenance therapy thereafter.

For allergy testing, greater than 42 patch tests will be reviewed by individual consideration. Documentation of medical necessity for over 42 tests will be necessary. Specific IghE in vitro testing is limited to 20 allergen specific antibodies. Refer to separate medical policy titled “Allergy Testing.”

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see the Blue Cross NC web site at www.bcbsnc.com .

Applicable service codes: See Guidelines

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

Editing for maximum units of service is not limited to the specific codes listed in this policy.

Related Policy

Allergy Skin and Challenge Testing (Medical Policy)

Epidural Steroid Injections for Back Pain (Medical Policy)

Outpatient Code Editor (OCE) Edits

Radiology Services

Supply and Equipment Reimbursement

References

Centers for Medicare and Medicaid Services (CMS). Medically Unlikely Edits. Available at: CMS

Medical Director review 3/2012

Centers for Medicare and Medicaid Services (CMS). Local Coverage Determination (LCD): Glucose Monitors (L11520). Available at: Local Coverage Determination for Glucose Monitors (L11520)

Medical Director review 6/2013

Medical Director review 2/2015

American Medical Association, Current Procedural Terminology (CPT®)

Healthcare Common Procedure Coding System

American College of Surgeons. Physicians as Assistants at Surgery. https://www.facs.org/-/media/files/advocacy/pubs/2020-physicians-as-assistants-at-surgery-consensus.ashx

Centers for Disease Control and Prevention, International Classification of Diseases, 10th Revision

Centers for Medicare & Medicaid Services, CMS Manual System, and Medicare Claims Processing Manual 100-04

History

3/30/12	New payment policy developed. BCBSNC will not provide reimbursement for claims with units that exceed the assigned maximum for that procedure. The total number of units will be adjusted to the maximum and the excess units will be denied. Notification given 3/30/12 for effective date 5/29/12. (and)
7/1/2013	Blood glucose test or reagent strips (A4253) is limited to 20 units (boxes) per quarter for patients with insulin dependent diabetes, and 6 units (boxes) per quarter for patients with non-insulin dependent diabetes. (and)
5/13/14	Policy category changed from "Corporate Medical Policy" to "Corporate Reimbursement Policy". No changes to policy content. (and)
5/27/14	Per unit reimbursement for allergy immunotherapy is based on the number of dosages prepared and intended for administration. Allergy immunotherapy is limited to 180 units for the first year of therapy during escalation, and 120 units for yearly maintenance therapy thereafter. Policy noticed on May 27, 2014 for effective date July 29, 2014. (and)
8/26/14	Statement added to section "Guidelines related to Maximum Units" that reads: When CPT code 88305 is submitted for greater than 10 units with prostate related diagnoses, the corresponding G-code will be substituted. (and)
2/24/15	Deleted the paragraph in the Guidelines section that read: "Daily maximum units edits may be applied to surgical pathology and microscopic examination to be consistent with the submitted diagnosis. Units billed in excess of the maximum per day limits will be denied. Additional maximum unit editing is applied to CPT Code 88305 (Level IV – Surgical pathology, gross and microscopic examination) to allow for multiple biopsies related to gastrointestinal diagnoses. When CPT code 88305 is submitted for greater than 10 units with prostate related diagnoses, the corresponding G-code will be substituted." (and)
4/28/15	Multi-lead collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan (CPT 77338) is reported once per IMRT plan and is limited to 3 units per 60 day treatment course. Notification given 4/28/2015 for effective date 6/27/2015. (and)
12/30/16	Routine review. No change to policy. (an)
2/24/17	Statement added to section "Guidelines related to Maximum Units" that reads: Mastectomy bras are limited to two per year. (an)

10/27/17	The following statement added to Guidelines section: For allergy testing, greater than 42 patch tests will be reviewed by individual consideration. Documentation of medical necessity for over 42 tests will be necessary. Specific IgE in vitro testing is limited to 36 allergen specific antibodies. Refer to separate medical policy titled "Allergy Testing." The following statement added to Billing/Coding section: Editing for maximum units of service is not limited to the specific codes listed in this policy. (an)
12/29/17	Routine review. No change to policy. (an)
2/23/18	Gradient compression stockings (A6530 – A6549) are limited to 6 pair per year. Notification given 2/23/2018 for effective date 4/27/2018. (an)
12/31/18	Routine review. No change to policy. (an)
1/14/20	Routine policy review. Senior Medical Director approved 12/2019. No changes to policy statement. (an)
6/9/20	Policy statement revised to read: BCBSNC will not provide reimbursement for claims with units that exceed the assigned maximum for that procedure. If a procedure code that is assigned a maximum unit value is reported with a greater unit count, the claim line will be denied, and the provider will be responsible for resubmitting the claim only for the number of units up to but not exceeding the allowed maximum. Statements in the Guidelines section revised for consistency. (bb)
12/17/20	Policy statement revised to read: BCBSNC will not provide reimbursement for claims with units that exceed the assigned maximum for that service. The total number of units will be adjusted to the maximum and the excess units will be denied. Statements in the Guidelines section revised for consistency in allowing up to maximum units without requiring provider to resubmit except for lab claims. Drug code max units added to Guidelines. Routine policy review. Medical Director approved 12/2020. Notification given 12/17/2020 for effective date 2/23/2021. (eel)
4/20/21	Policy format update. No changes to policy statement. (eel)
7/1/21	Specific unit limits for blood glucose supplies, mastectomy bras and gradient compression stockings moved to new reimbursement policy titled "Supply and Equipment Reimbursement". (eel)
12/30/21	Routine policy review. Medical Director approved. (eel)
6/1/22	Policy language updated throughout. Specific Unit Limits added to Reimbursement Guidelines section. IgE testing limit updated from 36 to 20. Medical Director approved. **Notification on 3/31/2022 for effective date 6/1/2022**. (eel)
12/31/2022	Routine policy review. Minor revisions only. (ckb)
12/31/2022	Added Autonomic Nervous System (ANS) Function Testing (CPT® 95921 – 95924) is limited to one per year. **Notification on 12/31/2022 for effective date 03/01/2023.** (cjw)
6/23/2023	Added FIT testing limited to once per year to Reimbursement Guidelines. Medical Director approved. **Notification on 6/30/2023 for effective date 8/29/2023**. (tlc)

Application

These reimbursement requirements apply to all commercial, Administrative Services Only (ASO), and Blue Card Inter-Plan Program Host members (other Plans members who seek care from the NC service area). This policy does not apply to Blue Cross NC members who seek care in other states.

This policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benef its are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.