BlueCross BlueShield of North Carolina

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Corporate Reimbursement Policy

Maximum Units of Service

File Name:	maximum_units_of_service_edits
Origination:	2/2012
Last Review:	12/2019
Next Review:	12/2020

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 derived from several sources: CMS, AMA CPT (American Medical Association Current Procedural Terminology), knowledge of anatomy, the standards of medical practice, 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

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.

Benefits Application

This medical 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 medical policy.

Guidelines Related to Maximum Units

Procedure 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 procedure, the claim will be denied. Providers are responsible for resubmitting the claim with the allowed number of units.

Some procedure codes have been assigned a maximum number of units that may be billed within a 12 month period for a member. Those services would not be done more than once within a year, or twice a year for

bilateral procedures. If a provider bills a number of units that exceed the annual assigned allowable unit(s) for that procedure for a member, the claim will be denied.

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. A claim with units billed in excess of the maximum allowable per anatomical site will be denied.

Certain obstetrical diagnostic services may have assigned maximum units per day limits based upon presence or absence of diagnosis codes indicative of multiple gestation. A claim with units billed in excess of the maximum per day limits will be denied.

Team surgery and co-surgery maximums are handled separately and are edited based on the same provider, not 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 claim will be denied.

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

Specific Unit Limits (not an all inclusive list):

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.

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 IgE in vitro testing is limited to 36 allergen specific antibodies. Refer to separate medical policy titled “Allergy Testing.”

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.

Mastectomy bras are limited to two per year.

Gradient compression stockings (A6530 – A6549) are limited to 6 pair per year.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

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.

Scientific Background and Reference Sources

Centers for Medicare and Medicaid Services (CMS). Medically Unlikely Edits. Available at: http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp

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

Policy Implementation/Update Information

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.** (adn)
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. (adn)
5/13/14	Policy category changed from "Corporate Medical Policy" to "Corporate Reimbursement Policy". No changes to policy content. (adn)
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. (adn)
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. (adn)
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." (adn)
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. (adn)
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)