Payment Policy: Maximum Units of Service

Reference Number: LA.PP.007
Product Types: ALL
Last Review Date: 06/2023

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
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. The Maximum Units of Service policy is derived from several sources: CMS, AMA CPT (American Medical Association Current Procedural Terminology), knowledge of anatomy, 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.

The purpose of this policy is to define payment criteria for the maximum units of service billed on a claim to be used in making payment decisions and administering benefits.

Application
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.

Reimbursement
Claim lines exceeding the maximum allowable units are denied.

Utilization
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.

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.

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 CMS, NCCI, or specialty society guidelines.
4. Guidelines defined in the applicable state Medicaid provider manuals, fee schedules, etc.
5. 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).
6. 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).
7. Clinical judgment considerations and determinations are based on input from physicians and certified coders.
8. This policy and analysis of claims data.
9. Fee schedules, provider manuals, bulletins or contracts.
10. Prescribing and FDA guidelines.
11. If the prescribing information defined a maximum daily dose, this value is used to determine the maximum units' value. For some drugs there is an absolute maximum daily dose. For others there is a maximum "recommended" or "usual" dose. In the latter two cases, the daily dose calculation is evaluated against claims data.
12. If the maximum daily dose calculation is based on actual body weight, a dose based on a weight range of 110-150 kg is evaluated against the claims data. If the maximum daily dose calculation is based on ideal body weight, a dose based on a weight range of 90-110 kg is evaluated against claims data. If the maximum daily dose calculation is based on body surface area (BSA), a dose based on a BSA range of 2.4-3.0 square meters is evaluated against claims data.
13. Published off label usage of a drug is considered for the maximum daily dose calculation.
14. The maximum unit values for some drug codes are set to 0. The rationale for such value includes but is not limited to: discontinued manufacture of drug and non-FDA approved compounded drug.

Non-drug related HCPCS/CPT codes may be assigned an MUE of 0 for a variety of reasons including, but not limited to: outpatient hospital MUE value for surgical procedure only performed as an inpatient procedure.

Many surgical procedures may be performed bilaterally. The NCCI program requires that bilateral surgical procedures be reported using modifier 50 with one unit of service. If a bilateral surgical procedure is performed at different sites bilaterally (e.g., transforaminal epidural injections (CPT codes 64480, 64489), one unit of service may be reported for each site; that is, the HCPCS/CPT code may be reported with modifier 50 and one unit of service for each site at which it was performed bilaterally.

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.

A denial of services due to a maximum unit is a coding denial, not a medical necessity denial. HCPCS/CPT codes that are denied based on maximum units may not be billed to Medicaid beneficiaries.

Most maximum unit values are set so that a provider would only very occasionally have a claim line denied. 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? and (3) Why does the provider's practice differ from national patterns?

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.

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.

Maximum units of service are applied to all claims for the same patient, same provider, on the same date of service. All units billed will be counted regardless of whether they are on the same

or different lines and the same or different claims. Any units above the allowed amount will be denied.

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.

Related Policies
Not Applicable

Related Documents or Resources
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, 2023. Available at https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicaid/medicaid-ncci-reference-documents

References
1. *Current Procedural Terminology (CPT®)*, 2022
2. *HCPCS Level II*, 2022

Revision Log	Revision Date	Approval Date
Converted corporate to local policy.	8/15/2020	
Annual Review; Updated: Clinical to Payment policy in "important reminder"	8/25/2022	
Annual Review; In Related documents or resources, date and link updated. Dates updated in references.	6/16/2023	9/13/2023

Important Reminder
This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and

limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This payment policy is the property of LHCC. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.