MAXIMUM UNITS OF SERVICES

Origination: 6/2022
Last Review: 11/2024

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.

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 service will be denied in its entirety.

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. Claims billed in excess of the maximum units allowed 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, that procedure 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. Any service billed with an anatomical modifier for more than one unit of service will be adjusted accordingly.

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, that procedure 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. Surgeries 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, all units for the service 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):

Allergy Management Services
Specific IgE in vitro testing is limited to 30 allergen specific antibodies.

Screening Services
Cardiovascular disease screening is limited to 1 unit per calendar year when submitted with a cardiovascular disease screening diagnosis.

Diabetic screening is limited to 1 unit per calendar in members that have not been diagnosed with prediabetes or have never been tested for diabetes. An additional diabetes screening will be when the member has been diagnoses with prediabetes and a follow-up screening is necessary, usually six months after the initial screening.

Therapeutic Radiology Services
Brachytherapy element is not separately reimbursable when billed with remote after-loading high intensity brachytherapy.

Basic radiation dosimetry calculation is limited to ten units per eight weeks by any provider. Special dosimetry is limited to six units per eight weeks by any provider.

Simulation reimbursement is limited to five units per eight weeks. 3-dimensional radiotherapy planning is limited to three times per eight weeks.

Intensity modulated radiotherapy dose planning is only reimbursable once per eight weeks.

Individual services performed as part of the development of intensity modulated radiotherapy dose planning are not separately reimbursable when performed the day of or within 30 days (prior to, or after) of a billed intensity modulated radiotherapy dose planning service by the same group practice for the same member.

Design and construction of multi-lead collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT) is reported once per IMRT plan and is limited to 3 units per eight weeks.

A radiation therapy management complete course of therapy that is 2 or less fractions is limited to 1 session per eight weeks.

Radiation therapy treatment device reimbursement is limited to seven units per eight weeks. An additional 5 units may be reimbursed services with a head, neck or prostate cancer diagnosis or when performed within two weeks before or after IMRT or SBRT.

Therapeutic radiology treatment planning is limited to one unit per eight weeks when performed by any provider for the same course of treatment.

Radiation treatment management services should only be reported once per week by any provider. Services integral to radiation treatment management services and brachytherapy are not separately reimbursable.

Special treatment procedures are only reimbursable within two weeks of a complex therapy as defined by the American Society for Radiation Oncology (ASTRO).

Therapeutic port films are only reimbursable once per week.

Stereotactic Radiosurgery (SRS) for cranial lesions (simple or complex) is reported once per course of treatment and is limited to once per two weeks. Additional cranial lesions should not be reported more than four times for an entire course of treatment (two weeks) regardless of the number of lesions treated.

SRS for spinal lesions is reported once per course of treatment and is limited to one unit per two weeks. Additional spinal lesions should not be reported more than two times for the entire course of treatment (two weeks) regardless of the number of lesions treated and may be reported only once per lesion.

Treatment management for SBRT is limited to one visit per two-week treatment course.

Stereotactic body radiation treatment and stereotactic radiosurgery treatment should not be reported more than five sessions for an entire course of treatment regardless of number of lesions treated. Since a treatment course is typically defined as two weeks, this combination of codes should only be reported up to five times per two weeks.

Additionally, stereotactic radiation treatment delivery and stereotactic radiosurgery represent a complete course of stereotactic radiosurgery treatment and should not be reported more than once for a single two-week course of treatment.

Stereotactic radiation treatment management of cranial lesion[s], complete course of treatment consisting of 1 session should not be reported more than once in a two-week treatment course.

Pain Management Services
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.

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 eight times per region in 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.

Behavioral Health Services
Psychiatric diagnostic evaluations (CPT® 90791 and 90792 or any combination thereof) are limited to no more than three units per year.

Rationale

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

Outpatient Code Editor (OCE) Edits

Supply and Equipment Reimbursement

References

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

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

Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual. Publication 100-04. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912

American Medical Association, Current Procedural Terminology (CPT®)

American Society for Therapeutic Radiology and Oncology (ASTRO) https://www.astro.org

ASTRO 2024 Radiation Oncology Coding Resource

Centers for Medicare & Medicaid Services, HCPCS Level II

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

History

6/1/22	New policy developed. Medical Director approved. **Notification on 3/31/2022 for effective date 6/1/2022**. (eel)
12/31/22	Routine Policy Review. Minor revisions only. (cjw)
4/1/2024	Language clarification in Policy and Reimbursement Guidelines regarding excess billed units. No change to policy intent. (tlc)
2/01/2025	Maximum units and frequency language updated for Therapeutic Radiology Services section. RPOC approved. **Notification on 12/01/2024 for effective date 2/01/2025.** (ss)

Application

These reimbursement requirements apply to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services.

This policy relates only to the services or supplies described herein. Please refer to the Member's Evidence of Coverage (EOC) 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. Benefits 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.