



Maximum Units of Service

POLICY

To ensure that Magnolia Health Plan's (Magnolia) providers have knowledge and understanding of the reimbursement methodology and coverage guidelines for the reimbursement for Maximum Units of Service. Magnolia will not provide reimbursement for claims with units that exceed the assigned maximum for that procedure.

POLICY DEFINITION

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.

REIMBURSEMENT INFORMATION

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

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 excess units 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.

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

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 and prostate diagnoses.

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 excess units will be denied.

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

CODING

CPT/HCPCS Codes: Magnolia Health Plan may specify CPT/HCPCS Codes to assist providers with identifying a CPT/HCPCS Code typically used to report a given service. In most instances CPT/HCPCS Codes are purely advisory; unless specified in the policy services reported under other CPT/HCPCS Codes are equally subject to this payment policy. Complete absence of all CPT/HCPCS Codes indicates that coverage is not influenced by CPT/HCPCS Code and the policy should be assumed to apply equally to all CPT/HCPCS Codes.

ICD-9-CM Procedure Code: Magnolia Health Plan may specify ICD-9 CM Procedure Codes to assist providers with identifying a code typically used to report a given service. Absence of an ICD-9 CM code does not guarantee that the policy does not apply to that procedure. Complete absence of all ICD-9 CM code indicates that coverage is not influenced by the ICD-9 CM code and the policy should be assumed to apply equally to all claims.

ICD-9 Codes that Support Medical Necessity: The correct usage of an ICD-9 CM code listed in the "ICD-9 Codes that Support Medical Necessity" section does NOT guarantee coverage or reimbursement of a service. The service must be reasonable & necessary in the specific case and must meet the criteria as outlined in this payment policy.

REFERENCES

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

Claims are subject to payment edits that are updated at regular intervals and generally based on CMS, Correct Coding Guidelines, Specialty Society Guidelines, and National Correct Coding Initiative.

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.



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 PSHP reserves the right to review and revise its medical policies periodically.

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISSUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO MAGNOLIA HEALTH PLAN MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OR THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY.