MEDICARE REIMBURSEMENT POLICY

Maximum Units Per Day

Active

Section: General Coding
Policy Number: 009
Effective Date: 05/01/24

Description

This policy addresses the reimbursement of Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes submitted with multiple units on the same date of service. This policy applies to services submitted on a professional (837P) claim.

Definitions

Unit: A basis of measurement for a specific procedure as defined within the HCPCS/CPT code narrative.

Medically Unlikely Edits (MUE): The maximum number of units the Centers for Medicare and Medicaid Services (CMS) allows by the same provider for the same patient on the same date of service.

Policy Statement

Blue Cross and Blue Shield of Minnesota (Blue Cross) requires each service submitted on a professional claim (837P), be submitted with a unit of measurement.

Blue Cross has established maximum units per day values that generally align with CMS MUE, in addition to CPT/HCPCS code descriptions, industry standards, and what is clinically appropriate for a specific service. For additional information on the reporting of units, refer to Appendix A, Section A.3.2 Units, of the AUC Minnesota Uniform Companion Guide.

This reimbursement policy applies whether a physician or other qualified healthcare professional (QHP) submits one CPT or HCPCS code with multiple units on a single claim line or multiple claim lines with one or more unit(s) on each line, under the same claim or different claim numbers.

The units billed that exceed the maximum allowable will be denied as provider liability.

Documentation Submission

Documentation must identify and describe the services performed. An appeal may be submitted with medical records to support the billing of units greater than the unit limit or MUE.

Coverage

Eligible services will be subject to the subscriber benefits, the applicable fee schedule amount, and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies, and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier: N/A
ICD-10 Diagnosis: N/A
ICD-10 Procedure: N/A
CPT/HCPCS: N/A
Revenue Codes: N/A

Resources

Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)
Centers for Medicare & Medicaid Services (CMS)

Policy History

03/24/2015	Initial Committee Approval
02/23/2021	Annual Policy Review
07/27/2021	Revised
05/23/2023	Annual Policy Review
04/23/2024	Annual Policy Review