Maximum Frequency Per Day Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, the enrollee's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals. This policy does not apply to: Network Durable Medical Equipment (DME) providers, home health services and home health agencies; anesthesia management; ambulance

services; network physicians and other qualified health care professionals contracted at a case rate (in some markets known as a flat rate) unless the code description for the service or supply indicates it should be reported only once daily. Maximum Frequency Per Day (MFD) limits for codes with a Medically Unlikely Edits (MUE) Adjudication Indicator (MAI) of 2 apply to all except DME providers. For Healthcare Common Procedure Coding System (HCPCS) codes reported with rental modifiers (KH, KI, KJ, KR, or RR) or the Maintenance and Service modifier (MS) by a participating network and non-network durable medical equipment (DME), orthotics or prosthetics vendor, please refer to UnitedHealthcare's Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency Policy.

Policy

Overview

The purpose of this policy is to ensure that UnitedHealthcare reimburses physicians and other qualified health care professionals for the units billed without reimbursing for obvious billing submission and data entry errors or incorrect coding based on anatomic considerations, HCPCS/CPT code descriptors, CPT coding instructions, established UnitedHealthcare policies, nature of a service/procedure, nature of an analyte, nature of equipment, and unlikely clinical treatment. The term “units” refers to the number of times services with the same Current Procedural Terminology (CPT ®) or HCPCS codes are provided per day by the same individual physician or other qualified health care professional. To do this, UnitedHealthcare has established MFD values, which are the highest number of units eligible for reimbursement of services on a single date of service. Reimbursement also may be subject to the application of other UnitedHealthcare Reimbursement policies. This policy applies whether a physician or other qualified health care professional 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. It is common coding practice for some CPT and HCPCS codes to be submitted with multiple units.

MFD values will be evaluated and/or updated quarterly to reflect new, changed, and deleted codes. Review of MFD values for existing CPT and HCPCS codes based on criteria within this policy will be completed quarterly.

For the purpose of this policy, the same individual physician or other qualified health care professional is the same individual rendering health care services reporting the same Federal Tax Identification number.

Reimbursement Guidelines

MFD Determination

Part I
The following criteria are first used to determine the MFD values for codes to which these criteria are applicable:

- The Centers for Medicare and Medicaid Services (CMS) Medically Unlikely Edit (MUE) value, where available, may be utilized to establish an MFD value, including unlisted codes.
- When the service is classified as bilateral (Indicators 1 or 3 on the CMS National Physician Fee Schedule [NPFS]) or the term 'bilateral' is included in the code descriptor and when no MUE value has been established for these codes, the MFD value is one (1). There are some codes that describe more than one anatomical site or vertebral level that can be treated bilaterally where the MFD value may be more than 1.
- The CPT or HCPCS code description/verbiage indicates the number of times the service can be performed, in which case the MFD value is set at that value.
- The service is anatomically or clinically limited (e.g. anatomical site, vertebral level, dosage, units of measure and coding guidelines) with regard to the number of times it may be performed, in which case the MFD value is established at that value.
- CMS Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Local Coverage Determination (LCD) assigns an MFD value in which case the MFD value is set at that value.
- Where no other definitive value has been established based on the criteria above, drug HCPCS codes will have an MFD value of 999 which indicates they bypass the MFD policy.

- Where no other definitive value has been established based on the criteria above, new CPT codes released by the American Medical Association and new HCPCS codes released by CMS (which are not covered by any of the above criteria), will have an MFD value of 100.

Part II
When none of the criteria listed in Part I apply to a code, data analysis is conducted to establish MFD values according to common billing patterns.

- When a code has 50 or more claim occurrences in a data set (excluding HCPCS drug codes), the MFD values are determined through claim data analysis and are set at the 100th percentile (i.e. the highest number of units billed for that CPT or HCPCS code in the data set). If the 100th percentile exceeds the 98th percentile by a factor of four, the MFD value will be set at the 98th percentile.
- When a code (excluding HCPCS drug codes) has less than 50 claim occurrences in a data set, the MFD values will be set at the default of 100 until the next annual analysis.
- In any case where, in UnitedHealthcare's judgment, the 98th percentile does not account for the clinical circumstances of the services billed, the MFD for a code may be increased so as to capture only obvious billing submission and data entry errors.

The "MFD CPT Values" and the "MFD HCPCS Values" lists below contain the current MFD values/codes.

Maximum Frequency per Day CPT Policy List

Maximum Frequency per Day HCPCS Policy List

Reimbursement

The MFD values apply whether a physician or other qualified health care professional 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. It is common coding practice for some CPT and HCPCS codes to be submitted with multiple units. However, when reporting the same CPT or HCPCS code on multiple and/or separate claim lines, the claim line may be classified as a duplicate service.

Services provided are reimbursable services up to and including the MFD value for an individual CPT or HCPCS code. In some instances, a modifier may be necessary for correct coding and corresponding reimbursement purposes. See Q & A #3, 4 and 5.

Modifiers LT and RT Restrictions

Bilateral payment via the use of modifiers LT or RT is inappropriate for procedures, services, and supplies where the concept of laterality does not apply. UnitedHealthcare will pay up to the maximum frequency per day value for codes with "bilateral" or "unilateral or bilateral" in description or for codes where the concept of laterality does not apply, whether submitted with or without modifiers LT and/or RT by the same individual physician or other qualified health care professional on the same date of service for the same member. Use of modifiers LT and/or RT on the codes identified in the "Codes Restricting Modifiers LT and RT" list will be considered informational only.

Codes Restricting Modifiers LT and RT

There may be situations where a physician or other qualified health care professional reports units accurately and those units exceed the established MFD value. In such cases, UnitedHealthcare will consider additional reimbursement if reported with an appropriate modifier such as modifier 59, 76, 91, XE, XS, or XU. Medical records are not required to be submitted with the claim when modifiers 59, 76, 91, XE, XS, or XU are appropriately reported. Documentation within the medical record should reflect the number of units being reported and should support the use of the modifier.

Medically Unlikely Edit (MUE) Adjudication Indicator (MAI) 2

CMS has identified CPT/HCPCS codes where the units of service (UOS) on the same date of service in excess of the MUE value would be considered impossible because it is contrary to statute, regulation or sub-regulatory guidance. Therefore, UnitedHealthcare will not allow units in excess of the MFD value to be reimbursed for CPT/HCPCS codes assigned an MAI indicator of "2". Per CMS guidelines, no modifier override will be allowed, however, anatomic modifiers may be considered when appropriate.

MFD MAI2 Indicator Codes

Modifiers

Modifier	Modifier Description
59	**Distinct Procedural Service** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different size or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.
76	**Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional** It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.
91	**Repeat Clinical Diagnostic Laboratory Test** In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.
XE	**Separate Encounter** A Service That Is Distinct Because It Occurred During A Separate Encounter
XS	**Separate Structure** A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
XU	**Unusual Non-Overlapping Service** The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

Anatomic Modifiers

Modifier	Modifier Description	Modifier	Modifier Description
E1	Upper left, eyelid	**E3**	Upper right, eyelid
E2	Lower left, eyelid	**E4**	Lower right, eyelid
F1	Left hand, second digit	**F5**	Right hand, thumb
F2	Left hand, third digit	**F6**	Right hand, second digit
F3	Left hand, fourth digit	**F7**	Right hand, third digit
F4	Left hand, fifth digit	**F8**	Right hand, fourth digit
FA	Left hand, thumb	**F9**	Right hand, fifth digit
T1	Left foot, second digit	**T5**	Right foot, great toe
T2	Left foot, third digit	**T6**	Right foot, second digit
T3	Left foot, fourth digit	**T7**	Right foot, third digit
T4	Left foot, fifth digit	**T8**	Right foot, fourth digit
TA	Left foot, great toe	**T9**	Right foot, fifth digit
LC	Left circumflex coronary artery	**RC**	Right coronary artery
LD	Left anterior descending coronary artery	**RI**	Ramus intermedius coronary artery
LM	Left main coronary artery	**RT**	Right side
LT	Left side		

Questions and Answers	
1	**Q:** Why are DME, network home health services and home health agencies, anesthesia management, and ambulance providers excluded from this policy? **A:** There are many contracts specific to these physicians and other qualified health care professionals that permit codes to be used in a different manner than intended by CPT and HCPCS, which make the application of this policy unworkable. Billing practices may also dictate that the units field is used to report something other than how many times a service was performed (i.e. mileage), which again may make the application of this policy unworkable. These providers were excluded until contract language and/or billing practices can be reviewed and changed.
2	**Q:** When the frequency of a billed service, drug or supply on a date of service is greater than the established MFD value, will there be additional reimbursement? **A:** When a physician or other qualified health care professional reports units accurately, yet those units exceed the established MFD value, an appropriate modifier such as 59, 76, 91, XE, XS, or XU may be utilized. The MFD value is a threshold set solely to avoid overpayment due to billing and data entry errors. UnitedHealthcare intends to reimburse all services performed and reported with proper coding in accordance with its reimbursement policies and benefit or provider contracts. Medical records do not need to be submitted for the purposes of this policy, unless the processed claim is being submitted on appeal. When reporting the same CPT or HCPCS code on multiple and/or separate claim lines, the claim line may be classified as a duplicate service.
3	**Q:** Why has UnitedHealthcare set the MFD value at 1 for bilateral procedures? **A:** UnitedHealthcare has set the MFD value for most bilateral procedures at 1. The preferred method of billing a bilateral eligible procedure is with 1 unit on one claim line with modifier 50. Modifier 50 indicates that one procedure was performed bilaterally. Bilateral eligible procedures may also be billed with modifiers RT and LT, but must be reported on two separate lines with 1 unit each. There are some codes that describe more than one anatomical site

<table>
<tr><td></td><td>or vertebral level that can be treated bilaterally where the MFD value may be more than 1.</td></tr>
<tr><td>4</td><td>Q: Would the MFD value for bilateral procedures remain at 1 unit if it is possible to perform these procedures more than once per day?

A: If the bilateral procedure is provided more than once per day, modifiers 59, 76, or XS may be appropriate to bill depending on the circumstance. Additional reimbursement will be considered with the use of these modifiers.</td></tr>
<tr><td>5</td><td>Q: Would the MFD value for hand or foot bilateral procedures remain at 1 unit if it is possible to perform the procedure on multiple digits such as fingers or toes?

A: The MFD value would remain at 1 unit, however, HCPCS modifiers FA or F1-9 may be used to report specific fingers; TA or T1-9 may be used to report specific toes.</td></tr>
<tr><td>6</td><td>Q: Will UnitedHealthcare allow more than 1 unit for a CPT or HCPCS code with “per diem” or “per day” in the code description?

A: UnitedHealthcare will allow 1 unit of a procedure code with “per diem” or “per day” or other verbiage describing once daily in the code description.</td></tr>
<tr><td>7</td><td>Q: What is an example of a code that is limited because of anatomical or clinical reasons?

A: CPT code 44950- Appendectomy would be set at the MFD value of 1 unit because a person only has one appendix.</td></tr>
<tr><td>8</td><td>Q: How should 90460 and/or 90461 be reported when multiple immunizations <u>with</u> face-to-face counseling are performed on the same date of service? For example, if the physician or other qualified health care professional administers immunizations for a 2-month-old infant on the same date of service according to the current immunization schedule, how should the following immunizations be reported?

<table>
<tr><th>Immunization</th><th>Components</th><th>CPT Code</th></tr>
<tr><td>DtaP intramuscular administration</td><td>3</td><td>90460</td></tr>
<tr><td></td><td></td><td>90461 x 2</td></tr>
<tr><td>Rotavirus oral administration</td><td>1</td><td>90460</td></tr>
<tr><td>Hepatitis B and Hemophilus influenza b intramuscular administration</td><td>2</td><td>90460</td></tr>
<tr><td></td><td></td><td>90461</td></tr>
<tr><td>Poliovirus intramuscular administration</td><td>1</td><td>90460</td></tr>
<tr><td>Pneumococcal conjugate vaccine</td><td>1</td><td>90460</td></tr>
</table>

A: Coding practices may vary by physician or other qualified health care professional offices. It is appropriate to report the immunization administration of the first and additional vaccine/toxoid component <u>with</u> face-to-face counseling on one line with multiple units and a link to all associated ICD-10-CM codes or report each component on a separate line. In the example above, the claim could be reported as 90460 with 5 units on one line and 90461 with 3 units on a separate line with the associated ICD-10-CM diagnoses linked to each line.

It is also appropriate to report the administration of each vaccine component on separate lines; e.g. reporting 5 lines for 90460 with 1 unit each and 3 lines for 90461 with 1 unit each. However, when reporting the same CPT or HCPCS code on multiple lines and/or on separate claims, the additional claim line(s) reported with the same procedure code may be denied as a duplicate service.</td></tr>
<tr><td>9</td><td>Q: How are MFD values for immunization administration CPT codes 90472 and 90474 determined?</td></tr>
</table>

	A: UnitedHealthcare follows the recommendations from the Center for Disease Control's (CDC) Advisory Committee on Immunization Practices (ACIP) to set the MFD value for additional immunization administration codes.
10	**Q:** What is an example of a CPT or HCPCS codes where the "description/verbiage" clearly indicates the number of units that can be performed on a single date of service? **A:** Two examples are CPT Codes 11102 and 80305. Code 11102-Tangential biopsy of skin, (eg, shave, scoop, saucerize, curette); single lesion. Because the code description includes "single lesion", it should only be billed with 1 unit. Code 80305 - Drug test(s) presumptive, any number of drug classes, any number of devices or procedures capable of being read by direct optical observation only (eg, utilizing immunoassay [eg, dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service. The code description includes "per date of service," therefore it should only be billed with 1 unit per date of service.
11	**Q:** Why are many new CPT and HCPCS codes set at an MFD value of 100? **A:** There is no CMS MUE value, data or previous claim history for new codes. Setting the MFD value at 100 allows claims to be processed and prevents most overpayments from occurring due to billing errors and data entry errors. Once there is a CMS MUE value or claims data available on a code, the MFD value will be established based on the hierarchy of the Reimbursement Guidelines MFD Determination listed above.
12	**Q:** What is an example of determining the MFD value at the 100th percentile unless the 100th percentile exceeds the 98th percentile by greater than a factor of 4? **A:** Statistical calculation: (A) x 4 = (C); if (B) is greater than (C), then the 98th percentile is set for the MFD value. If (B) is less than or equal to (C), then the 100th percentile is set for the MFD value. Here are two examples of determining MFD values based on a factor of 4.

Code	(A) Units @ 98th	(B) Units @ 100th	(C) Factor of 4	Set MFD at:
86902	14	27	56	27
E0676	2	30	8	2

Attachments	
MFD CPT Codes Policy List	Designates the maximum frequency per day value assignments for CPT codes.
MFD HCPCS Codes Policy List	Designates the maximum frequency per day value assignments for HCPCS codes.
MFD Codes Restricting Modifiers LT and RT	Codes that allow up to the MFD value that have "bilateral" or "unilateral or bilateral" in the description or where the concept of laterality does not apply.
MAI2 Indicator Codes	Codes that CMS has identified where the Units of Service (UOS) on the same date of service in excess of the MUE value would be considered impossible, however, anatomic modifiers may be considered when appropriate.

Resources
American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services Centers for Disease Control and Prevention, *Advisory Committee on Immunization Practices* Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

History	
9/29/2019	Policy Version Change Policy Reimbursement Guidelines updated Attachments Section MAI2 Indicator Codes Description updated Policy List Change: MFD CPT, HCPCS, Codes Restricting Modifiers LT and RT and MAI2 Indicator Codes Policy lists updated
8/5/2019	Policy Version Change Policy List Change: MFD CPT, HCPCS, Codes Restricting Modifiers LT and RT Policy lists updated
7/7/2019	Annual Anniversary Date and Policy Version Change Application Section updated Policy Reimbursement Guidelines: MFD Determination and Reimbursement updated Questions and Answers: Q&A #'s 2 and 6 updated, Q&A 12 updated and renumbered to 11, Q&A's #11 and 14 removed Policy List Change: MFD CPT, HCPCS and Codes Restricting Modifiers LT and RT
4/25/2019	Policy Version Change Policy List Change: MFD CPT and HCPCS Policy lists updated
4/7/2019	Policy Version Change Policy List Change: MFD CPT, HCPCS and MAI2 Indicator Codes Policy lists updated
3/31/2019	Policy Version Change Policy List Change: MFD HCPCS, Codes Restricting Modifiers LT and RT
2/17/2019	Policy Version Change Title section: Removed Annual Approval information & moved policy # to the header Attachment Section Update: MFD CPT and Codes Restricting Modifiers LT and RT Policy lists updated
1/1/2019	Policy Version Change Policy List Change: MFD CPT, HCPCS, Codes Restricting Modifiers LT and RT and MAI2 Indicator Codes Policy lists updated Questions and Answers: Q&A #10 updated Entries prior to 1/1/2017 archived
11/18/2018 – 12/31/2018	Policy Version Change Removed reference to Community and State and Medicare and Retirement in the Application section. Policy List Change: MFD CPT, HCPCS, and MAI2 Indicator Codes Policy Lists updated
9/30/2018 – 11/17/2018	Policy Version Change Added "Professional" to title Policy List Change: MFD CPT, HCPCS, and Codes Restricting Modifiers LT and RT Policy lists updated
7/11/2018	Policy Approval Date Change (No new version)
7/1/2018 – 9/29/2018	Policy List Change: MFD CPT, HCPCS, and Codes Restricting Modifiers LT and RT Policy lists updated
4/1/2018 – 6/30/2018	Policy List Change: MFD CPT, HCPCS, and Codes Restricting Modifiers LT and RT Policy lists

	updated
2/18/2018 – 3/31/2018	Application and Reimbursement Sections updated Policy List Change: MFD CPT Policy list updated Questions and Answers: Q&A #1 updated
2/11/2018 – 2/17/2018	Application and Policy Sections updated Policy List Change: MFD CPT, HCPCS, and MAI2 Indicator Codes Policy lists updated Questions and Answers: Q&A's #1,2,3,8,10 and 14 updated
1/1/2018 – 2/10/2018	Annual Policy Version Change Policy List Change: MFD CPT, HCPCS, Codes Restricting Modifiers LT and RT and MAI2 Indicator Codes Policy lists updated Entries prior to 1/1/2016 archived
11/19/2017 – 12/31/2017	Policy List Change: MFD CPT, HCPCS, and Codes Restricting Modifiers LT and RT Policy lists updated Questions and Answers: Q&A #14 updated
10/1/2017 – 11/18/2017	Policy List Change: MFD CPT, HCPCS, and MAI2 Indicator Codes Policy lists updated
9/17/2017 – 9/30/2017	Policy List Change: MFD HCPCS Policy list updated
8/20/2017 – 9/16/2017	Policy List Change: MFD CPT and HCPCS Policy lists updated
7/12/2017	Policy Approval Date Change (No new version)
7/2/2017– 8/19/2017	Policy List Change: MFD CPT, HCPCS, Codes Restricting Modifiers LT and RT and MAI2 Indicator Codes Policy lists updated
5/28/2017 – 7/1/2017	Policy List Change: MAI2 Indicator Codes Policy List updated
5/20/2017 – 5/27/2017	Preamble and Logo Updated Policy List Change: MAI2 Indicator Codes Policy List added
4/2/2017 -5/19/2017	Policy List Change: MFD CPT and HCPCS Policy lists updated
2/12/2017 – 4/1/2017	Policy List Change: MFD CPT, HCPCS and Codes Restricting Modifiers LT and RT Policy lists updated
1/8/2017 – 2/11/2017	Policy List Change: MFD HCPCS and Codes Restricting Modifiers LT and RT Policy lists updated
1/1/2017 – 1/7/2017	Annual Policy Version Change Questions and Answers: Q&A #10 updated Policy List Change: MFD CPT, HCPCS and Codes Restricting Modifiers LT and RT Policy lists updated Entries prior to 1/1/2015 archived