MAXIMUM FREQUENCY PER DAY POLICY

Policy Number: ADMINISTRATIVE 169.63 T0 **Effective Date**: January 1, 2019

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Related Policy

- Refer to the Application and Question and Answers sections of the policy

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

APPLICATION

This reimbursement policy applies to services reported using the UB-04 claim form, the 1500 Health Insurance Claim Form (a/k/a CMS-1500), or their electronic equivalents or their successor forms. This policy applies to all network and non-network providers, including hospitals, ambulatory surgical centers, 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 Durable Medical Equipment (DME) providers, network home health services and home health agencies, anesthesia management, ambulance services, or 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 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 participating network and non-network durable medical equipment (DME), orthotics or prosthetics vendor, please refer to policy titled *Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency*.

OVERVIEW

The purpose of this policy is to ensure that Oxford reimburses physicians, hospitals, ambulatory surgical centers, and other health care professionals for the units billed without reimbursing for obvious billing submission and data entry errors or incorrect coding based on anatomic considerations, Current Procedural Terminology (CPT ®)/HCPCS code descriptors, CPT coding instructions, established Oxford 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 CPT or HCPCS codes are provided per day by the same individual physician or other health care professional. To do this, Oxford has established MFD values, which are the highest number of units eligible for reimbursement of services on a single date of service. This policy applies whether a physician, hospital, ambulatory surgical center, or other 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 annually.

For the purpose of this policy, the same individual physician, hospital, ambulatory surgical center, or health care professional is the same physician, hospital, ambulatory surgical center or health care professional 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 service is classified as bilateral (CMS Indicators 1 or 3) on the Centers for Medicare & Medicaid Services (CMS) National Physician Fee Schedule (NPFS) or the term 'bilateral' is included in the code descriptor. For the majority of 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.
- Where the CPT or HCPCS code description/verbiage references reporting the code once per day, the MFD value is 1.
- The service is anatomically or clinically limited with regard to the number of times it may be performed, in which case the MFD value is established at that value.
- 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.
- CMS Durable Medical Equipment Medicare Administrative Contractor (DMEMAC) Local Coverage Determination (LCD) assigns an MFD value in which case the MFD value is set at that value.
- Where the criteria above have not defined an MFD value, the CMS Medically Unlikely Edits (MUE) value, where available, will be utilized to establish an MFD 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 are exempt from the MFD policy.
- Where no other definitive value has been established based on the criteria above, unlisted CPT and HCPCS codes will have an MFD value of 999 which indicates they are exempt from 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 since the last MFD value update (not covered by any of the above criteria), will have an MFD value of 100.

MFD Determination: 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, 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 will be set at the 98th percentile.
- When a code 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 Oxford'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 per Day Policy List" list below contains the most current MFD values. Maximum Frequency Per Day List

The MFD values apply whether a physician, hospital, ambulatory surgical center, or other 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 and/or may be subject to additional Oxford reimbursement policies.

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. Oxford 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, hospital, ambulatory surgical center, or other healthcare 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, hospital, ambulatory surgical center, or other healthcare professional reports units accurately and those units exceed the established MFD value. In such cases, Oxford 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 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, Oxford 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. CMS MUE

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 or 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 or 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 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 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. To report a separate and distinct E/M service performed on the same date, see modifier 25. It is also inappropriate to use modifier 76 to indicate repeat laboratory services. Modifiers 59 or 91 should be used to indicate repeat or distinct laboratory services, as appropriate according to the AMA and CMS. Separate consideration for reimbursement will not be given to laboratory codes reported with modifier 76.

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

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 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, hospital, ambulatory surgical center, or other healthcare 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. Oxford 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 and subject to additional Oxford reimbursement policies.
3	Q:	Why has Oxford set the MFD value at 1 for bilateral procedures?
	A:	Oxford 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 or vertebral level that can be treated bilaterally where the MFD value may be more than 1.
4	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.
5	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.
6	Q:	Will Oxford allow more than 1 unit for a CPT or HCPCS code with "per diem" or "per day" in the code description?
	A:	Oxford will allow 1 unit of a procedure code with "per diem" or "per day" or other verbiage describing once daily in the code description. There are no modifiers that will override the MFD value. For example, if a patient requires home infusion antibiotic therapy twice daily, it would be more appropriate to report 1 unit of HCPCS code S9501 rather than 2 units of S9500. The MFD applies whether a physician, hospital, ambulatory surgical center, or other health care professional submits one CPT or HCPCS code with multiple units on a single claim line or multiple claim lines with 1 or more unit(s) on each line. **S9500** - Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem. **S9501 -** Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem.
7	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.

8	Q:	How should 90460 and/or 90461 be reported when multiple immunizations with face-to-face counseling are performed on the same date of service? For example, if the physician, hospital, ambulatory surgical center, or other 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?

Immunization	Components	CPT Code
DtaP intramuscular administration	3	90460 90461 x 2
Rotavirus oral administration	1	90460
Hepatitis B and Hemophilus influenza B intramuscular administration	2	90460 90461
Poliovirus intramuscular administration	1	90460
Pneumococcal conjugate vaccine	1	90460

	A:	Coding practices may vary by physician, hospital, ambulatory surgical center, or other healthcare professional offices. It is appropriate to report the immunization administration of the first and additional vaccine/toxoid component with 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.
9	Q:	How are MFD values for immunization administration CPT codes, 90472 and 90474 determined?
	A:	Oxford 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 11100 and 80305. Code 11100 - Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion. Because the code includes "single lesion", it should only be billed with one (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 unlisted CPT and HCPCS codes set at an MFD value of 999?
	A:	Unlisted CPT and HCPCS codes are set at an MFD value of 999 because unlisted codes are individually reviewed. The review of documentation will identify the accurate number of services performed for the unlisted code.
12	Q:	Why are many new CPT and HCPCS codes set at an MFD value of 100?
	A:	There is no 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 claims data is available on a code, the MFD value will be established.
13	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

14	**Q:**	What is an example of a clinical circumstance where Oxford would assign a specific MFD value?
	A:	A4595 - Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES). According to standard criteria, the data showed the 98th percentile at 10 units and the 100th percentile at 72 units. The statistical calculation would have set the MFD value at 10. However, based on the code description allowance of "per month" and subject to the Oxford Reimbursement Policy titled *Time Span Codes* and the CMS MUE, the MFD value was decreased to 6.

ATTACHMENTS

Maximum Frequency Per Day Code List

A list designating the maximum frequency per day value assignments for CDT, CPT, and HCPCS codes

Maximum Frequency Per Day Code List

Codes Restricting Modifiers LT and RT

A list of codes that allow up to the MFD limit that have "bilateral" or "unilateral or bilateral" in the description or where the concept of laterality does not apply

Codes Restricting Modifiers LT and RT

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Payment Policy Oversight Committee. [*2018R0060D*]

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.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
01/01/2019	• Updated *Maximum Frequency Per Day Code List* [maximum frequency per day (MFD) value assignments for CDT/CPT/HCPCS codes] to reflect annual code edits: ○ Removed 0159T, 0188T, 0189T, 0190T, 0196T, 0337T, 0346T, 0359T, 0360T, 0361T, 0363T, 0364T, 0365T, 0366T, 0367T, 0368T, 0369T, 0371T, 0372T, 0374T, 0387T, 0388T, 0389T, 0390T, 0391T, 0406T, 0407T, 10022, 11100, 11101, 20005, 27370, 31595, 33282, 33284, 41500, 43760, 46762, 50395, 61332, 61480, 61610, 61612, 63615, 64508, 64550, 66220, 76001, 77058, 77059, 78270, 78271, 78272, 81211, 81213, 81214, 92275, 95974, 95975, 95978, 95979, 96101, 96102, 96103, 96111, 96118, 96119, 96120, 99090, J0833, J9310, K9030, Q4131, Q4172, Q9993, Q9994, Q9995, V5170, V5180, V5210, and V5220 • Updated *Codes Restricting Modifiers LT and RT* (CDT/CPT/HCPCS codes that allow up to the MFD limit that have "bilateral" or "unilateral or bilateral" in the description or where the concept of laterality does not apply) to reflect annual code edits: ○ Removed 0159T, 0188T, 0189T, 0196T, 0337T, 0346T, 0359T, 0360T, 0361T, 0363T, 0364T, 0365T, 0366T, 0367T, 0368T, 0369T, 0371T, 0372T, 0374T, 0387T, 0388T, 0389T, 0390T, 0391T, 11100, 11101, 33282, 33284, 41500, 43760, 46762, 61480, 61610, 61612, 63615, 76001, 77059, 78270, 78271, 78272, 81211, 81213, 81214, 95974, 95975, 95978, 95979, 96101, 96102, 96103, 96111, 96118, 96119, 96120, 99090, 81214, 92275, 95974, 95975, 95978, 95979, 96101, 96102, 96103, 96111, 96118, 96119, 96120,

Date	Action/Description
	99090, Q4172, Q9993, Q9994, Q9995, V5210, and V5220 • Archived previous policy version ADMINISTRATIVE 169.62 T0