UnitedHealthcare Community Plan

REIMBURSEMENT POLICY
CMS-1500
Policy Number 2024R0060B.LA

Maximum Frequency Per Day Policy, Professional for Louisiana

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 Community Plan reimbursement policies uses 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 Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include but are not limited to federal &/or state regulatory requirements, 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 the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan 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 reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

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 and 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 home health services and supplies/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. For 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 Community Plan's Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency Policy.

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Policy

Overview

The purpose of this policy is to ensure that UnitedHealthcare Community Plan reimburses physicians and other qualified health care professionals for the units billed without reimbursing for obvious billing submission, 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 Healthcare Common Procedure Coding System (HCPCS) codes are provided per day by the same individual physician or other qualified health care professional. To do this, UnitedHealthcare Community Plan has established maximum frequency per day (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 Community Plan Reimbursement policies such as "Laboratory Rebundling" or "Professional/Technical Component." 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 annually.

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

MUE Editing **NOTE: MUE values always supersede MFD values listed in this policy.**

UnitedHealthcare Community Plan will follow the CMS MUE values before any other MFD criteria is applied. If there is not a CMS MUE value or the CMS MUE value is not exceeded, then the following criteria has been used to establish MFD values. See UnitedHealthcare Community Plan’s Medically Unlikely Edits Policy

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 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 (DME MAC) 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.

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- 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.

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 value 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 UnitedHealthcare Community Plan'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 most current MFD values.

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 and/or subject to additional UnitedHealthcare Community Plan reimbursement policies such as "Laboratory Rebundling" or "Professional/Technical Component."

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.

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 Community Plan 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 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.

There may be situations where a physician or other qualified healthcare professional reports units accurately and those units exceed the established MFD value. In such cases, UnitedHealthcare Community Plan 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.

Anatomic Modifiers

E1	**E2**	**E3**	**E4**	**F1**	**F2**
F3	**F4**	**F5**	**F6**	**F7**	**F8**
F9	**FA**	**T1**	**T2**	**T3**	**T4**
T5	**T6**	**T7**	**T8**	**T9**	**TA**
LC	**LD**	**LM**	**LT**	**RC**	**RI**
RT					

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State Exceptions	
Louisiana	Louisiana has an MFD exception for HCPC codes 90472, H2034, and H2036. Code 77417 allows up to 4 units per day. H0015 had an exception from 2/01/2014 to 8/7/2022.

Questions and Answers	
1	**Q:** Why do you exclude network home health services and supplies/home health agencies, anesthesia management, and ambulance providers 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 on a date of service is greater than the established MFD value, will there be additional reimbursement? **A:** When a physician or other qualified 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. UnitedHealthcare Community Plan 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 UnitedHealthcare Community Plan reimbursement policies.
3	**Q:** Why has UnitedHealthcare Community Plan set the MFD value at 1 for bilateral procedures? **A:** UnitedHealthcare Community Plan 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 on two lines with 1 unit each and modifiers RT and LT. 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, XE, XS, or XU 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 UnitedHealthcare Community Plan 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. 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 or other

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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.

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Q: What is an example of a code that is limited because of anatomical or clinical reasons?

A: An Appendectomy would be set at the MFD value of 1 unit because a person only has one appendix.

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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 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?

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 or other qualified 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-9-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-9-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.

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Q: How are MFD values for immunization administration CPT codes 90472 and 90474 determined?

A: UnitedHealthcare Community Plan 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.

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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: Examples include, among others, services that include “single lesion,” “XX or more lesions,” or "per date of service" in the code description should be reported with 1 unit of service.

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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.

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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

13	**Q:** What is an example of a clinical circumstance where UnitedHealthcare Community Plan would assign a specific MFD value? **A:** Electrical stimulator supplies. 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 UnitedHealthcare Community Plan Time Span Codes Reimbursement Policy, the MFD value was decreased to one (1).

Attachments

Maximum Frequency Per Day (MFD) CPT Code Policy List	Designates the maximum frequency per day value assignments for CPT codes.
Maximum Frequency Per Day (MFD) HCPCS Policy List	Designates the maximum frequency per day value assignments for HCPCS codes.
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.

Resources

Individual state Medicaid regulations, manuals & fee schedules

American Medical Association, *Current Procedural Terminology (CPT®) Professional Edition* and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

History

10/06/2024	Policy Version Change State Exceptions: Louisiana updated Question & Answer Section: Updated #11 to remove definitions
2/25/2024	Policy Version Change Branding updated Modifiers: Removed definitions Question & Answer Section: Updated #6, #12 & #13 to remove definitions History Section: Entries prior to 2/25/2022 archived

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1/1/2023	Policy Version Change Removed H0015 exception that was effective from 2/1/2014 to 8/7/2022.
6/05/2022	Policy Version Change
1/6/2006	Policy implemented by UnitedHealthcare Community & State

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