Outpatient Hospital Maximum Frequency Per Day Policy (CES)

Policy Number: ADMINISTRATIVE 275.1 T0
Effective Date: June 1, 2021

Instructions for Use

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Related Policies
None

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 or its electronic equivalent or its successor form. This policy applies to all network and non-network outpatient hospital claims.

Overview

The purpose of this policy is to reimburse units billed for outpatient hospital services without reimbursing for obvious billing submission and data entry errors or incorrect coding based on anatomic considerations, Healthcare Common Procedure Coding System II (HCPCS)/Current Procedural Terminology (CPT®) 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 outpatient hospital. Oxford 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 Oxford Reimbursement policies and/or Provider contracts. This policy applies whether an outpatient hospital 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.

Reimbursement Guidelines

MFD Determination

The following criteria are 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, specifically the MUE table for Facility Outpatient Hospital Services.
- Codes assigned a CMS MUE value of zero will have MFD values established using the same criteria as CMS, including but not limited to anatomic considerations, CPT/HCPCS code descriptors, CPT coding instructions, nature of service/procedure, nature of an analyte, nature of equipment, and unlikely clinical treatment.
- If an MFD value is not listed, it's the responsibility of the outpatient hospital to bill the appropriate number of units for each service.

Reimbursement

The MFD values apply whether a hospital 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. Services provided are reimbursable services up to and including the MFD value for an individual CPT or HCPCS code.

There may be situations where a facility 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, XP, XS, or XU. Medical records are not required to be submitted with the claim when modifiers 59, 76, 91, XE, XP, 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, Oxford will not allow units in excess of the MFD value to be reimbursed for CPT/HCPCS codes assigned a MAI indicator of "2". Per CMS guidelines, no modifier override will be allowed, however, anatomic modifiers may be considered when appropriate.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies may apply.

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		

Maximum Frequency Per Day Code List
A list designating the Maximum Frequency per Day value assignments for CPT and HCPCS codes.
Maximum Frequency Per Day Code List

MAI2 Indicator Codes
A list of 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.
MAI2 Indicator Codes

Questions and Answers

1	Q:	Will the unit values apply to case rate payments?
	A:	No, unit values will be applied to claims that are paid at a discount or fee schedule.

References

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Reimbursement Policy Oversight Committee. [*2020R5011I*]

American Medical Association, Current Procedural Terminology (CPT®) 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

Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) Policy Publications

Policy History/Revision Information

Date	Summary of Changes
06/01/2021	• New Reimbursement 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 InterQual® criteria, to assist us in administering health benefits. The InterQual® criteria 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.