Summary

This policy describes reimbursement for claims submitted with multiple units for the same Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code on the same date of service.

Policy Statement

The purpose of this policy is to ensure that physicians and other health care professionals are reimbursed for units billed without reimbursing for obvious billing submission and data entry errors. To do this, maximum frequency per day (MFD) values have been established, which are the highest number of units automatically allowed for services on a single date of service.

MFD Determination

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

- The service is classified as bilateral (Centers for Medicare and Medicaid [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 bilateral codes, the MFD value is 1.
- The service has a published CMS Medically Unlikely Edit (MUE) value.
- 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 limit.
- 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 number.

Billing Units on One Claim Line or on Multiple Lines

This policy applies whether a provider 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.

Guidelines for Billing Units

When submitting multiple units of one code, the guidelines are based on code description:

- If the CPT or HCPCS code description contains per or each or another unit of measurement and multiple services are provided, providers should bill the code on one line with the appropriate number of units.
- If the CPT or HCPCS code description does not contain per or each, and multiples of that service are provided, providers may bill the code on one line with multiple units, or with an appropriate repeat service modifier on separate lines.
Reimbursement
- Reimbursable services submitted with multiple units will be reimbursed up to the maximum allowed units per day.
- Codes on the Anesthesia Policy RBRVS List submitted by anesthesiologists are subject to the MFD values.
- There may be situations where a provider bills units correctly and those units exceed the established MFD value. In such cases, Medica will provide additional reimbursement if supported by documentation.

Updates
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 occur on an ongoing basis.

Modifiers
- **Modifier 59** – Distinct procedural service.
- **Modifier 76** – Repeat procedure or service by same physician or other qualified health care professional.
- **Modifier 91** – Repeat clinical diagnostic laboratory test.
- **Modifier XE** – Separate encounter. A service that is distinct because it occurred during a separate encounter.
- **Modifier XS** – Separate structure. A service that is distinct because it was performed on a separate organ/structure.
- **Modifier XU** – Unusual non-overlapping service. The use of a service that is distinct because it does not overlap usual components of the main service.

Resources
- Centers for Medicare and Medicaid Services (CMS)
- Healthcare Common Procedure Coding System (HCPCS)
- National Physician Fee Schedule (NPFS)

Effective Date
1992
Revision Updates
05/11/2017   Annual policy review
01/01/2017   Annual code update
11/03/2016   Annual policy review
01/01/2016   Annual code update
10/02/2015   Annual policy review; code update
01/01/2015   Annual code update; accepted new X modifiers