Payment Policy: Maximum Units of Service

Reference Number: CC.PP.007
Product Types: ALL
Effective Date: 01/01/2013
Last Review Date: 11/15/2024

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Frequent billing errors can occur when assigning units the number of units to a procedure code. For example, the units for a drug may be incorrectly billed as the number of milligrams, e.g., 50, when the actual unit of service may be 1 (1 unit = 50 mg), or the descriptor for a CPT code may specify "bilateral," implying that the code includes both sides of the body, and the maximum units that may be billed is 1, not two. Maximum unit edits (MUE) are unit-of-service claim adjustments made to medical claims against a procedure code for medical services provided by one provider/supplier to one patient over a set period of time, typically one day. These claim edits compare different values on medical claims to a set of defined criteria to check for irregularities. Maximum unit edits are designed to limit fraud or coding errors.

The Maximum Unit of Service Edits and policy is derived from services like CMS, American Medical Association (AMA) Current Procedure Terminology (CPT), knowledge of anatomy, standards of medical practice, U.S. Food and Drug Administration (FDA) and other nationally recognized drug references, and outliner claims data from provider billing patterns.

The purpose of this policy is to define payment criteria for the maximum units of service billed on a claim to be used by the Health Plan in making payment decisions and administering benefits.

Application
This policy applies to any provider submitting claims for procedure codes for which maximum unit limits have been exceeded. The ideal maximum unit value for a HCPCS/CPT code allows the vast majority of appropriately coded claims to bypass editing.

Policy Description

Reimbursement
Claim lines exceeding the maximum allowable units are denied.

Utilization
This policy includes Medically Unlikely Edits (MUE) which include but are not limited to CMS Medicare and Medicaid. For most CPT/HCPCS codes, these changes specify the maximum units of service (UOS) that can be provided by the same provider to the same beneficiary on the same calendar date of service, during a set period of time, or over a beneficiary's lifetime.

This policy applies to all professional and outpatient facility claims coded with a CPT or HCPCS code. The maximum units value applies regardless of whether the code is reported on a single line, multiple lines, or multiple claims.

The use of CPT/HCPCS modifiers (e.g., 76, 77, 91, anatomic) may or may not impact the number of units allowed. State Medicaid agencies, fiscal agents or CMS may have rules limiting use of these modifiers with some HCPCS/CPT codes.

The maximum unit value for each HCPCS/CPT code is based on one or more of the following criteria:

1. Anatomic considerations may limit units of service based on anatomic structures. For example, the MUE value for an appendectomy is one since there is only one appendix.
2. The CPT code descriptors or CPT coding instructions in the CPT Manual may limit units of service.
3. Nationally recognized sources such CMS, NCCI, or specialty society guidelines.
4. Guidelines defined in the applicable state Medicaid provider manuals, fee schedules, etc.
5. The nature of a procedure/service may limit units of service and is in general determined by the amount of time required to perform a procedure/service (e.g., overnight sleep studies) or clinical application of a procedure/service (e.g., motion analysis tests).
6. The nature of equipment may limit units of service and is in general determined by the number of items of equipment that would be utilized (e.g., cochlear implant or wheelchair).
7. Clinical judgment considerations and determinations are based on input from physicians and certified coders.
8. Analysis of claims data.
9. Fee schedules, provider manuals, bulletins, or contracts.
10. Prescribing and FDA guidelines.
11. If the prescribing information defined a maximum daily dose, this value is used to determine the maximum units' value. For some drugs there is an absolute maximum daily dose. For others there is a maximum "recommended" or "usual" dose. In the latter two cases, the daily dose calculation is evaluated against claims data.
12. If the maximum daily dose calculation is based on actual body weight, a dose based on a weight range of 110-150 kg is evaluated against the claims data. If the maximum daily dose calculation is based on ideal body weight, a dose based on a weight range of 90-110 kg is evaluated against claims data. If the maximum daily dose calculation is based on body surface area (BSA), a dose based on a BSA range of 2.4-3.0 square meters is evaluated against claims data.
13. Published off label usage of a drug is considered for the maximum daily dose calculation.

14. The maximum unit values for some drug codes are set to 0. The rationale for such value includes but is not limited to discontinued manufacture of drug and non-FDA approved compounded drug.

Non-drug related HCPCS/CPT codes may be assigned an MUE of 0 for a variety of reasons including, but not limited to: outpatient hospital MUE value for surgical procedure only performed as an inpatient procedure.

Many surgical procedures may be performed bilaterally. The NCCI program requires that bilateral surgical procedures be reported using modifier -50 with one unit of service. If a bilateral surgical procedure is performed at different sites bilaterally (e.g., transforaminal epidural injections, CPT codes 64480 & 64489), one unit of service may be reported for each site; that is, the HCPCS/CPT code may be reported with modifier -50 and one unit of service for each site at which it was performed bilaterally.

Some state Medicaid agencies or fiscal agents allow providers to report repetitive services performed over a range of dates on a single line of a claim with multiple units of service. If a provider reports services in this fashion, the provider should report the "from date" and "to date" on the claim line. Contractors are instructed to divide the units of service reported on the claim line by the number of days in the date span and round to the nearest whole number. This number is compared to the maximum unit value for the code on the claim line.

Denial of service due to maximum units is a coding denial, not a medical necessity denial. Denied services based on maximum units may not be billed to CMS beneficiaries.

Most maximum unit values are set so that a provider would only very occasionally have a service denied. If a provider encounters a code with frequent denials due to maximum units, the provider should consider the following:

1. Is the HCPCS/CPT code being used correctly?
2. Is there a HCPCS/CPT code that more accurately reflects the services rendered?
3. Is the unit of service being counted and reported correctly? *and*
4. Why does the provider's practice differ from national patterns?

Since maximum units are coding edits rather than medical necessity edits, state Medicaid agencies or fiscal agents may have units of service edits that are more restrictive than CMS Medicare maximum unit values. In such cases, these more restrictive edits would be applied to the claim.

Additional Maximum Unit Edits

Anatomical modifiers E1-E4 (eyes), FA-F9 (fingers), and TA-T9 (toes) have a maximum allowable of 1 unit per anatomical site for a given date of service. Any service billed with an anatomical modifier for more than 1 unit of service will be adjusted accordingly.

Certain obstetrical diagnostic services may have assigned maximum units per day limits based upon presence or absence of diagnosis codes indicative of multiple gestation. For units that are billed over the maximum units per day limits will be denied.

Maximum units of service are applied to all claims for the same patient, same provider, on the same date of service. All units billed are counted regardless of whether they are on the same or different lines and the same or different claims. Units above the allowed amount will be denied.

Documentation Requirements
In the unusual clinical circumstance when the number of units billed on the claim legitimately exceeds the assigned maximum number for that procedure, clinical documentation of the number of units performed should be submitted for reconsideration of the denial.

Related Documents or Resources

1. Centers for Medicare and Medicaid Services. Chapter 1, General Correct Coding Policies. In: *National Correct Coding Initiative* Policy Manual for Medicaid Services. Revised January 1, 2025. https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicaid/medicaid-ncci-reference-documents

References
1. Current Procedural Terminology (CPT®), 2025
2. HCPCS Level II, 2025
3. https://www.cms.gov/medicare/coding-billing/ncci-medicare
4. https://www.cms.gov/medicare/coding-billing/ncci-medicaid
5. https://www.cms.gov/medicare/coding-billing/ncci-medicaid/medicaid-ncci-faq-library

Revision History	
04/19/2017	Converted to new template and conducted review.
05/11/2018	Conducted annual review
08/27/2019	Conducted review and updated policy
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/17/2021	Annual Review completed; no major changes required
12/01/2022	Annual Review completed; link to Medicaid policy manual updated
11/01/2023	Annual review completed, no major updates to the policy. Reviewed and updated dates from 2022 to 2023
03/08/2024	Annual review completed, no major updates to the policy.
11/15/2024	Annual review completed; no major updates to the policy.

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

 Providers, members and their representatives are bound to the terms and conditions expressed

herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.