Reimbursement Policy:

Maximum Frequency – Per Day (Commercial & Medicare)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RPC20230036	1/1/2021	RPC (Reimbursement Policy Committee)

Reimbursement Guideline Disclaimer: **We have policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. We will inform you of new policies or changes in policies through postings to the applicable Reimbursement Policies webpages on emblemhealth.com and connecticare.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.**

The information provided in our policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, we strive to minimize these variations.

We follow coding edits that are based on industry sources, including, but not limited to, CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. We use industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Overview:

CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.

EmblemHealth and ConnectiCare have established maximum daily frequency (MDF) values which are the highest number of units eligible for reimbursement of services on a single date of service.

Reimbursement may be subject to the application of other EmblemHealth/ConnectiCare reimbursement policies. This policy applies whether a physician or other qualified health care professional submits one CPT/HCPCS code with multiple units on a single claim line or multiple lines with one or more units on each line.

Policy Statement:

The maximum unit(s) per day or maximum daily frequency (MDF) is the maximum number of units EmblemHealth/ConnectiCare reimburses for a specific CPT/HCPCS code that is provided per day by the same individual physician or other qualified health care professional (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).

EmblemHealth/ConnectiCare utilize CMS maximum unit values or MUE for CPT/ HCPC codes, where available. The assigned unit value is subject to change and is not a guarantee of payment.

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CMS MUE Adjudication Indicators (Commercial and Medicare):

Table A below (reflects the CMS MUE Adjudication Indicators (MAI) that EmblemHealth/ConnectiCare apply for our Medicare and Commercial plans:

Table A (Commercial and Medicare)

CPT/HCPC Codes with CMS MUE Adjudication Indicator (MAI):	
MAI Indicator "1"	Adjudicated as a claim line edit. EmblemHealth/ConnectiCare may consider reimbursement of medically necessary units of service in excess of MUE when submitted with appropriate use of modifiers such as 59, 76, 91, XE, XS or XU. Medical records are not required to be submitted when modifiers 59, 76, 91, XE, XS or XU are appropriately reported. *Documentation within the medical record should reflect the number or units being reported and should support the use of the modifier.*
MAI Indicator "2"	Absolute criteria (date of service). These are "per day edits based on policy". CPT/HCPCS codes with an MAI of "2" have been rigorously reviewed and vetted within CMS and obtain this MAI designation because units of service (UOS) on the same date of service (DOS) in excess of the MUE value would be considered contrary to statute, regulation, or sub-regulatory guidance. EmblemHealth/ConnectiCare will not allow units in excess of the MUE value with MAI indicator "2" to be reimbursed. *Per CMS guidelines, no modifier override will be allowed.*
MAI Indicator "3"	Date of service edits. These are "per day edits based on clinical benchmarks". Units of service (UOS) on the same date of service (DOS) in excess of the MUE value are unlikely to appear on correctly coded claim but could, in unusual circumstances, be payable. EmblemHealth/ConnectiCare will deny claims submitted with excess MUEs; however a corrected claim can be submitted or the claim may be reconsidered upon appeal. Supporting medical documentation is required.

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EmblemHealth/ConnectiCare Maximum Daily Frequency allowable *(MDF):

EmblemHealth/ConnectiCare follow CMS guidelines and will not reimburse CPT/HCPCS codes with a MUE value of "0" (zero). This applies to all EmblemHealth/ConnectiCare **Medicare Advantage plans.**

For Medicare non-covered services that are covered by our Commercial plans, EmblemHealth/ConnectiCare have established MDF exceptions. These exceptions are listed by CPT Code in **Table B** below.

Table B: (*Commercial Plans only)

CPT Code:	CMS MUE:	EmblemHealth/ConnectiCare MDF Allowable:
92310	0	1
92314	0	1
92340	0	1
92591	0	1
92592	0	1
92593	0	1
92595	0	1
98943	0	1
99374	0	1
99375	0	1
J3535	0	1
S0265	0	8
S2066	0	2
S2067	0	2
S2068	0	2
S2083	0	1
S2095	0	3
S2112	0	2
S3845	0	1
S3854	0	1

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CPT Code:	CMS MUE:	EmblemHealth/ConnectiCare MDF Allowable:
S4011	0	1
S4015	0	1
S4016	0	1
S4017	0	1
S4018	0	1
S4020	0	1
S4021	0	1
S4022	0	1
S4023	0	1
S4025	0	1
S4027	0	1
S4035	0	1
S4037	0	1
S8030	0	2
S9001	0	1
S9128	0	1
S9152	0	1
S9452	0	1
S9454	0	1
S9455	0	1
S9460	0	1
S9465	0	1
S9470	0	1

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References:

1. CMS Claims Processing Manual and other CMS publications; www.cms.gov
2. American Medical Association Current Procedural Terminology (CPT®*) Professional Edition

Revision History

Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	4/5/2023	• Added S0265, S2066, S2067, S2068, S2083, S2095, S2112, S3845, S3854, S4011, S4015, S4016, S4017, S4018, S4020, S4021, S4022, S4023, S4025, S4027, S4035, S4037, S8030, S9001, S9128, S9152, and S9454 to Table B, **effective 8/13/2023.**
EmblemHealth ConnectiCare	2/01/2023	• Added S9452, S9455, S9460, S9465, and S9470 to Table B **effective 6/15/2023** • Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number
EmblemHealth	6/2021	• Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number
ConnectiCare	6/2021	• Updated to align with CMS
ConnectiCare	3/2019	• Included table of CPT Code MUE exceptions for our Commercial Plans. • Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number
ConnectiCare	9/2013	• Original Policy. Revised 1/2015