Maximum Units Payment Policy

Policy

The Plan assigns a maximum number of units allowed on select CPT and HCPCS codes that may be billed by the same provider or provider group. Services and subsequent payments are based on the member's benefit plan. Eligibility and benefit specifics should be verified prior to initiating services.

Definitions

Procedure Code Maximums – The Plan has assigned a maximum number of units for services that may only be billed per date of service, by the same provider or provider group.

Annual Maximums – The Plan has assigned a maximum number of units to select procedure codes that may be billed within a 12-month period by the same provider or provider group.

Lifetime Maximums – The Plan has assigned a maximum number of units to select procedure codes that may be billed within a member's lifetime by the same provider or provider group.

Reimbursement

Coverage is limited to the services that physicians and qualified non-physician practitioners are legally authorized to perform in accordance with state law. Reimbursement is made according to the contracted provider's applicable fee schedule. Reimbursement may vary depending on specific claim procedure code combinations and claim edits.

If the number of units billed exceeds the limit of units allowed for the service, the Plan will reject the claim line with the disposition of "Reject - too many units billed."

The unit assignment list is subject to change based on review of industry standard coding updates including, but not limited to, the CMS Medically Unlikely Edit (MUE) program.

Referral/notification/prior authorization requirements

Fallon Health Weinberg and NaviCare® models of care are based on patient care coordination; therefore, we encourage referring providers to contact the member's designated navigator if there are questions or concerns prior to prescribing tests, supplying equipment, or providing any other additional appointments or services that may not routinely be authorized or may require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

Billing/coding guidelines

Please report "from" and "to" dates for a series of identical services, and report the appropriate number of days (e.g., a correct submission would be: code 99231 Subsequent hospital care; from date January 1, 2009 to date January 7, 2009; number of units 7).

EDI Claim Submitter Information:

- Submit claims in HIPAA compliant 837P format for professional services. Claims billed with non-standard codes will reject if billed electronically.

Paper Claim Submitter Information:

- Submit claims on a CMS 1500 form for professional services. Claim lines billed with non-standard codes will deny.

Place of service

This policy applies to services rendered in all settings. This policy applies to services furnished by physicians and qualified non-physician practitioners in all areas and settings permitted under applicable laws.

Policy history

Origination date:	09/27/06
Previous revision date(s):	10/10/07 05/01/09 – Changed policy name from Units of Service Edit to Maximum Units; added codes to the procedure code maximum list; updated the language under policy, definitions, benefits application, reimbursement, referral/notification/ preauthorization requirements, and billing/coding guidelines. 01/01/10 - Added language in the reimbursement section discussing that the policy is subject to change based on review of industry standard coding updates including, but not limited to, the CMS Medically Unlikely Edit (MUE) program. 11/01/2015 - Annual review and moved to new Plan template. 09/01/2016 - Annual review.
Connection date & details:	July 2017 – Annual review. July 2018 – Annual review, no updates July 2019 – Annual review, no updates.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.