Maximum Units

Policy

AllWays Health Partners assigns a maximum number of allowed units for covered and payable CPT and HCPCS codes billed by the same provider and/or provider group. The unit maximum assigned is subject to change, with or without notice, based on industry coding review and updates including, but not limited to: Centers for Medicare and Medicaid Services (CMS) Medically Unlikely Edit (MUE) program, American Medical Association (AMA), and Correct Coding Initiative (CCI).

Authorization, Notification and Referral

All applicable Authorization, Notification, and Referral requirements apply. Please refer to the Prior Authorization, Notification, and Referral Guidelines grid for additional details and requirements. here.

Policy Limitations

This policy applies to all places of service in accordance with the National POS code set.

Member Cost Sharing

The provider is responsible for verifying at each encounter and when applicable for each day of care when the patient is hospitalized, coverage, available benefits, and member out-of-pocket costs; copayments, coinsurance, and deductible required, if any. AllWays Health Partners suggests that providers do not bill the member for services prior to adjudication of claim(s) in order for the accurate member responsibility to be calculated. Any member responsibility for copayments, coinsurance, and/or deductible will be reflected on the Explanation of Payment (EOP) and the member's Explanation of Benefits (EOB).

Service Limitations

Reimbursement will be made up to the maximum units allowed per service, in conjunction with the member's available benefits on the date of service. Reimbursement is limited to physicians, mid-level practitioners and qualifying health care professionals in compliance with any limitations set forth in this policy.

Any units exceeding the daily maximum allowed will be denied and are considered the provider's liability. Providers are not permitted to balance bill AllWays Health Partners' members for any services denied with the following EOP messages:

- **Claims Adjustment Remit Code (CARC) Edit 50:** *These are non-covered services because this is not deemed a 'medical necessity' by the payer.*
- **Remark Adjustment Reason Code (RARC) Edit N362**: *The number of days or units of service exceeds our acceptable maximum.*

Billing Limitations

- All claims must be submitted within (90) days of the date of service
- All claims must be submitted using current industry standard codes
- Submit the most appropriate modifier when applicable with the corresponding service code(s)

Definitions

Maximum Units: The assigned maximum number of units for covered services which may only be billed and reimbursed per date of service, by the same provider and/or provider group.

Annual Maximums: The assigned maximum number of units for covered services which may be billed and reimbursed within a 12-month period by the same provider and/or provider group.

Lifetime Maximums: The assigned maximum number of units for covered services which may be billed and reimbursed within a member's lifetime.

References

Current year CPT, Professional Edition published by the AMA (American Medical Association)
http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

Publication History

Topic: Maximum Units	Owner: Network Management

January 1, 2014 *Original Publication*
January 1, 2019 *Document restructure; codes, code descriptor and references updated*