

Maximum Units

Reimbursement Policy ID: RPC.0023.2100

Recent review date: 11/2025

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy describes limitations on payment based on units of service to providers contracted with the health plan.

Most services and supplies have a maximum unit of service that is allowed within a designated time (e.g., per day), due to the type of service or supply when furnished by the same provider. A physician or other qualified health care professional from the same group practice in the same specialty with the same Tax Identification Number (TIN) is considered the same provider.

The health plan follows the American Medical Association (AMA) Current Procedural Terminology (CPT), Centers for Medicare & Medicaid (CMS) Healthcare Current Procedure Coding System (HCPCS), CMS Medicaid National Correct Coding Initiative (NCCI), and other industry guidelines based on medical practice

standards in regard to maximum unit of service. Only medically necessary services and/or supplies are reimbursed.

Exceptions

N/A

Reimbursement Guidelines

The health plan uses edits to prevent payment for services and supplies exceeding their maximum units of service that are normally allowed within the designated period of time:

- Maximum unit edits include CMS Medicaid NCCI Medically Unlikely Edits (MUEs). If the units on a single claim line exceed the MUE value for the procedure code on that claim line, the claim line will deny. See Reimbursement Policy RPC.0024.2100 Medically Unlikely Edit (MUE).
- Maximum unit edits are not limited to MUEs. If the units on a claim line or a claim exceed the maximum units allowable for a procedure code within their designated time, the claim line or claim will deny.
- CPT/HCPCS code descriptions and other coding manual instructions often indicate the maximum units for procedure codes. See Reimbursement Policy RPC.0007.2100 for Add-On Codes.
- Appropriate modifier(s) indicate the circumstance(s) for which the same procedure code on multiple claim lines for the same date of service will be considered for payment. See Reimbursement Policy RPC.0013.2100 regarding duplicate services.

Providers must submit clean claims for accurate reimbursement of services and/or supplies.

See Reimbursement Policy RPC.0025.2100 on Frequency.

Refer to CPT/HCPCS manuals for complete descriptions of procedure codes and their modifiers, Medicaid NCCI coding policy manuals.

Definitions

Same Individual Physician or Other Qualified Health Care Professional

A physician or other health care professional from the same group practice with the exact same specialty and subspecialty reporting under the same Federal Tax Identification number (TIN).

Medically Unlikely Edits (MUEs)

An MUE is the maximum units of service that are normally allowable for the same service or supply, represented as a CPT/HCPCS procedure code, on the same date of service, and by the same provider.

Edit Sources

- I. Current Procedural Terminology (CPT) and associated publications and services
- II. Healthcare Common Procedure Coding System (HCPCS)
- III. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

Associated Policies

RPC.0007.2100 Add-On Codes

Maximum Units

RPC.0013.2100 Duplicate Services
RPC.0024.2100 Medically Unlikely Edit (MUE)
RPC.0025.2100 Frequency

Policy History

10/2026	<ul style="list-style-type: none">Removed the next review dateReplaced the plan name with “the health plan”
11/2025	Reimbursement Policy Committee Approval
10/2025	Biennial Review <ul style="list-style-type: none">No major changes
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
11/2024	Reimbursement Policy Committee Approval
10/2024	Annual Review <ul style="list-style-type: none">Updated definitions
04/2024	Revised preamble
01/2024	Reimbursement Policy Committee Approval
	Precedes Act 319