Maximum Frequency Per Day Reimbursement Policy					
Policy Number	2019RP503A	**Annual Approval Date**	3/27/2019	**Approved By**	Optum Behavioral Reimbursement Committee

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the procedure code or codes that correctly describe the health care services provided to individuals whose behavioral health benefits are administered by Optum, including but not limited to UnitedHealthcare members. This reimbursement policy is also applicable to behavioral health benefit plans administered by OptumHealth Behavioral Solutions of California.

Our behavioral health reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other procedure coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to services billed on the UB-04 claim form and to electronic claim submissions (i.e., 837p and 837i) and for claims submitted online through provider portals. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.*

This information is intended to serve only as a general reference resource regarding our reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, Optum may use reasonable discretion in interpreting and applying this policy to behavioral health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for behavioral health care services provided to members. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: member's benefit coverage, provider contracts and/or legislative mandates. Finally, this policy may not be implemented exactly the same way on the different electronic claim processing systems used by Optum due to programming or other constraints; however, Optum strives to minimize these variations.

Optum may modify this reimbursement policy at any time by publishing a new version of the policy on this website. However, the information presented in this policy is accurate and current as of the date of publication.

**CPT® is a registered trademark of the American Medical Association*

Applicability

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, to services billed on the UB-04 claim form and to electronic claim submissions (i.e., 837p and 837i) and for claims submitted online through provider portals. This policy applies to all products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

The purpose of this policy is to ensure that Optum reimburses physicians and other qualified health care professionals for the units billed without reimbursing for obvious billing submission and data entry errors or incorrect coding based on HCPCS/CPT code descriptors, CPT coding instructions, established Optum policies, nature of a service/procedure, nature of an analyte, nature of equipment, and unlikely clinical treatment. The term "units" refers to the number of times services with the same Current Procedural Terminology (CPT ®) or HCPCS codes are provided per day by the same individual physician or other qualified health care professional. To do this, Optum has established MFD values, which are the highest number of units eligible for reimbursement of services on a single date of service. Reimbursement also may be subject to the application of other Optum Reimbursement policies. This policy applies whether a physician or other qualified health care professional

submits one CPT or HCPCS code with multiple units on a single claim line or multiple claim lines with one or more unit(s) on each line. It is common coding practice for some CPT and HCPCS codes to be submitted with multiple units.

MFD values will be evaluated and/or updated quarterly to reflect new, changed, and deleted codes. Review of MFD values for existing CPT and HCPCS codes based on criteria within this policy will be completed quarterly.

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.

Reimbursement Guidelines

MFD Determination:

The following criteria are first used to determine the MFD values for codes to which these criteria are applicable:

- The Centers for Medicare and Medicaid Services (CMS) Medically Unlikely Edit (MUE) value, where available, may be utilized to establish an MFD value, including unlisted codes.
- Where the CPT or HCPCS code description/verbiage references reporting the code once per day, the MFD value is 1.
- The CPT or HCPCS code description/verbiage indicates the number of times the service can be performed, in which case the MFD value is set at that value
- The CPT or HCPCS code description/verbiage indicates the number of times the service can be performed, in which case the MFD value is set at that value.
- Where no other definitive value has been established based on the criteria above, unlisted CPT and HCPCS codes will have an MFD value of 999 which indicates they bypass from the MFD policy.
- Where no other definitive value has been established based on the criteria above, new CPT codes released by the American Medical Association and new HCPCS codes released by CMS which are not covered by any of the above criteria, will have an MFD value of 100.

Reimbursement:

The MFD values apply whether a physician or other qualified health care professional submits one CPT or HCPCS code with multiple units on a single claim line or multiple claim lines with one or more unit(s) on each line. It is common coding practice for some CPT and HCPCS codes to be submitted with multiple units. However, when reporting the same CPT or HCPCS code on multiple and/or separate claim lines, the claim line may be classified as a duplicate service.

Services provided are reimbursable services up to and including the MFD value for an individual CPT or HCPCS code. In some instances, a modifier may be necessary for correct coding and corresponding reimbursement purposes.

There may be situations where a physician or other qualified health care professional reports units accurately and those units exceed the established MFD value. In such cases, Optum will consider additional reimbursement if reported with an appropriate modifier such as modifier 59, XE, or XU. Medical records are not required to be submitted with the claim when modifiers 59, XE, or XU are appropriately reported. Documentation within the medical record should reflect the number of units being reported and should support the use of the modifier.

Medically Unlikely Edit (MUE) Adjudication Indicator (MAI) 2

CMS has identified CPT/HCPCS codes where the units of service (UOS) on the same date of service in excess of the MUE value would be considered impossible because it is contrary to statute, regulation or sub-regulatory guidance. Therefore, Optum will not allow units in excess of the MFD value to be reimbursed for CPT/HCPCS codes assigned an MAI indicator of "2". Per CMS guidelines, no modifier override will be allowed.

Questions and Answers	
1	**Q:** Will Optum allow more than 1 unit for a CPT or HCPCS code with “per diem” or “per day” in the code description? **A:** Optum will allow 1 unit of a procedure code with “per diem” or “per day” or other verbiage describing once daily in the code description.
2	**Q:** Why are many new CPT and HCPCS codes set at an MFD value of 100? **A:** There is no CMS MUE value, data or previous claim history for new codes. Setting the MFD value at 100 allows claims to be processed and prevents most overpayments from occurring due to billing errors and data entry errors. Once there is a CMS MUE value or claims data available on a code, the MFD value will be established based on the hierarchy of the Reimbursement Guidelines MFD Determination listed above.

Resources
www.cms.gov CMS NCCI Medically Unlikely Edits American Medical Association (AMA) Current Procedural Terminology (CPT) Manual Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

History / Updates	
April, 2022	Anniversary review; No updates
May, 2021	Annivesary review; No updates
May, 2020	Anniversary Review
July, 2019	Policy Reimbursement Guidelines: MFD Determination and Reimbursement updated Resource section added direct CMS and NCCI Medicically Unlikely Edits link
March, 2019	New policy