Maximum Units

Reimbursement Policy ID: RPC.0023.5420

Recent review date: 01/2026

Next review date: 12/2026

Healthy DC 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. Healthy DC 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 Healthy DC.

Most services and supplies have a maximum unit of service that is normally allowed within a designated (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.

Healthy DC follows Department of Health Care Finance (DHCF), 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 regards to a maximum units of service. Only medically necessary services and/or supplies are reimbursed.

Exceptions

N/A

Reimbursement Guidelines

Healthy DC utilizes 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 Medicare and 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 excess units will be denied. (See Reimbursement Policy RPC.0024.5420 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 excess units will be denied.

- CPT/HCPCS code descriptions and other coding manual instructions often indicate the maximum units for procedure codes. (See Reimbursement Policy RPC.0007.5420 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.0013.5420 regarding duplicate services).

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

See Reimbursement Policy RPC.0025.5420 on Frequency.

Refer to CPT/HCPS manuals for complete descriptions of procedure codes and their modifiers, Medicaid NCCI coding policy manuals, and Department of Health Care Finance (DHCF) billing resources for fee schedules and billing guidelines.

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).

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)
IV. Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI): https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci

Associated Policies

RPC.0007.5420: Add-On Codes
RPC.0013.5420: Duplicate Services
RPC.0024.5420: Medically Unlikely Edit (MUE)
RPC.0025.5420: Frequency

Policy History

11/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by Healthy DC from Policy History section
01/2023	Template revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section