Reimbursement Policy	
Subject: Maximum Units Per Day	
Policy Number: **G-15003**	Policy Section: **Administration**
Last Approval Date: **06/16/21**	Effective Date: **06/16/21**

Visit our provider website for the most current version of our reimbursement policies. If you are using a printed version of this policy, please verify the information by going to https://provider.healthybluela.com.

Disclaimer

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Healthy Blue if the service is covered by a member's Healthy Louisiana benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes, and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Healthy Blue reimbursement policies are developed based on nationally accepted industry standards and coding principles.

Healthy Blue reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to our provider website.

Policy

Healthy Blue allows reimbursement for a procedure or service that is billed for a single member, on a single date of service, by the same provider and/or provider group up to the maximum number of units allowed per day unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

When the number of units assigned to a procedure or service exceeds the daily maximum allowed, the units billed in excess of the maximum per day limit will not be eligible for reimbursement.

When a provider appropriately bills units that exceed the maximum units allowed, documentation must be provided for consideration of reimbursement.

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Maximum Units Per Day edits do not affect National Correct Coding Initiative (NCCI) edits. For more information on NCCI edits, please see our Code and Clinical Editing reimbursement policy.

Note: The maximum units per day are based on claims data analysis.

Related Coding

Policy Section	Code(s)	Verbiage, if needed
N/A	N/A	Standard Correct Coding Applies

Policy History

(06/16/21)	Biennial review approved: No changes made to the policy language
(11/26/19)	Biennial review approved and effective: Policy language updated
(04/06/18)	Review approved and effective: Policy language updated
(09/01/17)	Policy template updated
(03/14/16)	Initial policy approval **03/14/16** and effective **01/01/17**

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State Medicaid Agency
- State Contract

Definitions

Maximum Units	The assigned maximum number of units per day for a procedure or service, which may be reported for a single member on a single date of service by the same provider and/or provider group.
General Reimbursement Policy Definitions	

Related Policies and Materials

Code and Clinical Editing Guidelines
Documentation Standards for Episodes of Care
Drugs and Injectable Limits