Maximum Units

Policy

Mass General Brigham Health Plan 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. Mass General Brigham Health Plan 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 providers/suppliers 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. For ACO claims, units per line should not exceed the MassHealth maximum units payable. Providers are not permitted to balance bill Mass General Brigham Health Plan's 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.

Medical and Payment Policy Home Page

Medical Policies
Provider Payment Guidelines

References

CMS, Medicaid NCCI Edit Files
CMS, Medicare NCCI Medically Unlikely Edits (MUEs)
Current year CPT, Professional Edition published by the AMA (American Medical Association)
MassHealth Maximum Units Payable

Mass General Brigham Health Plan

Provider Payment Guidelines

Publication History

Topic: Maximum Units	Owner: Network Management

January 1, 2014	*Original Publication*
January 1, 2019	*Document restructure; codes, code descriptor and references updated*
January 1, 2023	*Document rebrand*
January 1, 2024	*Annual review, no policy change*
January 1, 2025	*Annual review, no policy change*
June 26, 2026	*Added links for Medical and Payment Policies*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc. and Mass General Brigham Health Plan Insurance Company.