

## Maximum Frequency Per Day Policy, Professional

### 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 code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other 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 those billed on UB04 forms. 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 UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

**Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include but are not limited to federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.**

Finally, this policy may not be implemented the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan 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 Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.

### Application

**This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.**

This policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and 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. This policy does not apply to: network home health services and supplies/home health agencies; anesthesia management; ambulance services; network physicians and other qualified health care professionals contracted at a case rate (in some markets known as a flat rate) unless the code description for the service or supply indicates it should be reported only once daily. For HCPCS codes reported with rental modifiers (KH, KI, KJ, KR, or RR) or the Maintenance and Service modifier (MS) by a participating network and non-network durable medical equipment (DME), orthotics or prosthetics vendor, please refer to UnitedHealthcare Community Plan's Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency Policy.

### Table of Contents

#### [Application](#)

#### [Policy](#)

#### [Overview](#)

#### [Reimbursement Guidelines](#)

#### [MFD Determination](#)

#### [Part I](#)

#### [Part II](#)

#### [Reimbursement](#)

#### [Modifiers](#)

#### [Anatomic Modifiers](#)

#### [State Exceptions](#)

[Questions and Answers](#)  
[Attachments](#)  
[Resources](#)  
[History](#)

## Policy

### Overview

The purpose of this policy is to ensure that UnitedHealthcare Community Plan reimburses physicians and other qualified health care professionals for the units billed without reimbursing for obvious billing submission, data entry errors or incorrect coding based on anatomic considerations, HCPCS/CPT code descriptors, CPT coding instructions, established UnitedHealthcare Community Plan 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 Healthcare Common Procedure Coding System (HCPCS) codes are provided per day by the same individual physician or other qualified health care professional. To do this, UnitedHealthcare Community Plan has established maximum frequency per day (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 UnitedHealthcare Community Plan 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

#### **MUE Editing \*\*NOTE: MUE values always supersede MFD values listed in this policy except in Arizona. \*\***

UnitedHealthcare Community Plan will follow the CMS MUE values before any other MFD criteria is applied. If there is not a CMS MUE value or the CMS MUE value is not exceeded, then the following criteria has been used to establish MFD values. See UnitedHealthcare Community Plan’s Medically Unlikely Edits Policy.

### Part I

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

- Where the criteria above have not defined an MFD value, the CMS Medically Unlikely Edits (MUE) value, where available, will be utilized to establish an MFD value.
- When the service is classified as bilateral (Indicators 1 or 3 on the CMS National Physician Fee Schedule [NPFSS]) or the term 'bilateral' is included in the code descriptor and when no MUE value has been established for these codes, the MFD value is 1. There are some codes that describe more than one anatomical site or vertebral level that can be treated bilaterally where the MFD value may be more than 1.
- Where the CPT or HCPCS code description/verbiage references reporting the code once per day, the MFD value is 1.
- The service is anatomically or clinically limited with regard to the number of times it may be performed, in which case the MFD value is established 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.
- CMS Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Local Coverage Determination (LCD) assigns an MFD value in which case the MFD value is set at that value.
- Where no other definitive value has been established based on the criteria above, drug HCPCS codes will have an MFD value of 999 which indicates they are exempt from the MFD policy.

- 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 are exempt 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 since the last MFD value update (not covered by any of the above criteria), will have an MFD value of 100.

## Part II

When none of the criteria listed in Part I apply to a code, data analysis is conducted to establish MFD values according to common billing patterns.

- When a code has 50 or more claim occurrences in a data set, the MFD values are determined through claim data analysis and are set at the 100th percentile (i.e. the highest number of units billed for that CPT or HCPCS code in the data set). If the 100th percentile exceeds the 98th percentile by a factor of four, the MFD value will be set at the 98th percentile.
- When a code has less than 50 claim occurrences in a data set, the MFD values will be set at the default of 100 until the next annual analysis.
- In any case where, in UnitedHealthcare Community Plan's judgment, the 98<sup>th</sup> percentile does not account for the clinical circumstances of the services billed, the MFD for a code may be increased so as to capture only obvious billing submission and data entry errors.

The "MFD CPT Values" and the "MFD HCPCS Values" lists below contain the most current MFD values.

[UnitedHealthcare Community Plan Maximum Frequency Per Day \(MFD\) CPT Code Policy List](#)  
[UnitedHealthcare Community Plan Maximum Frequency Per Day \(MFD\) HCPCS Policy List](#)

## 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 and/or subject to additional UnitedHealthcare Community Plan reimbursement policies.

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. See Q & A #3, 4 and 5.

Bilateral payment via the use of modifiers LT or RT is inappropriate for procedures, services, and supplies where the concept of laterality does not apply. UnitedHealthcare Community Plan will pay up to the maximum frequency per day value for codes with "bilateral" or "unilateral or bilateral" in description or for codes where the concept of laterality does not apply, whether submitted with or without modifiers LT and/or RT by the same individual physician or other qualified healthcare professional on the same date of service for the same member. Use of modifiers LT and/or RT on the codes identified in the "Codes Restricting Modifiers LT and RT" list will be considered informational only.

[UnitedHealthcare Community Plan Codes Restricting Modifiers LT and RT](#)

There may be situations where a physician or other qualified healthcare professional reports units accurately and those units exceed the established MFD value. In such cases, UnitedHealthcare Community Plan will consider additional reimbursement if reported with an appropriate modifier such as modifier 59, 76, 91, XE, XS or XU. Medical records are not required to be submitted with the claim when modifiers 59, 76, 91, XE, XS 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.

Modifiers					
59	76	91	XE	XS	XU

Anatomic Modifiers					
E1	E2	E3	E4	F1	F2
F3	F4	F5	F6	F7	F8
F9	FA	T1	T2	T3	T4
T5	T6	T7	T8	T9	TA
LC	LD	LM	LT	RC	RI
RT					

State Exceptions	
<b>Arizona</b>	<p>Arizona Health Care Cost Containment System (AHCCCS) publishes a unit limit list specific to Arizona Medicaid.</p> <p>Arizona does not exclude network home health services and supplies/home health agencies; anesthesia management; ambulance services.</p> <p>Arizona unit values are allowed even if they are greater than the CMS MUE values. If Arizona has not published a unit limit for a code, the MUE value will be followed.</p>
<b>California</b>	<p>California is exempt from MFD for code 90471.</p> <p>California has an MFD exception for codes:</p> <p>Codes 96150 and 96151 has a limit of 1 unit per day</p> <p>Codes 96152, 96153 and 96154 has a limit of 2 units per day</p> <p>Codes 96367 and 96375 has a limit of 3 units per day</p> <p>Code G0277 has a limit of 4 units per day</p> <p>Code G9008 with modifier U1-U7 may be billed with up to 96 units; however, only 1 unit is reimbursable.</p> <p>Code 86235 has a limit of 5 units per day</p> <p>Code 96370 has a limit of 8 units per day</p> <p>Code A4217 has a limit of 12 units per day</p> <p>Code T1014 has a limit of 90 units per day</p> <p>Code T1019 has a limit of 96 units per day</p>
<b>Florida</b>	<p>Per state regulations, a different unit value is allowed for the following codes:</p> <p>CPT 92507 and 92508 = 4 units allowed</p> <p>HCPCS H0031 (MMA) = 80 units allowed</p> <p>HCPCS T1019 = 96 units per day</p> <p>HCPCS T1030 and T1031 = 4 units allowed</p> <p>HCPCS H2010, T1020, T1021, T1024 and T2033 = no unit limit</p> <p>HCPCS T1005 = 96 units per day</p>
<b>Hawaii</b>	<p>Hawaii Medicaid allows 96 units per day for S9122, S9123 &amp; S9124 when billed with modifier U2.</p>
<b>Kansas</b>	<p>Kansas Medicaid is exempt from the MFD policy limits for all codes except the following:</p> <p>Per State Regulations, HCPCS code T2046 is limited to 1 unit per day</p>
<b>Maryland</b>	<p>MD has an exception from CMS for the following codes:</p> <p>Allows 76 units per day on code V5266</p> <p>Allows 96 units per day on code T1019</p>
<b>Michigan</b>	<p>MI allows 8 units of 90472 in place of service 71</p> <p>T1019 is allowed 96 units per day</p>

<b>Mississippi</b>	MS Can has exceptions for codes T1025 and L0980 – L3600 T1019 is allowed 96 units per day
<b>Missouri</b>	MO utilizes its own list of units allowed per date of service.
<b>Nebraska</b>	Per State regulations, Nebraska Medicaid has exceptions to the following codes: Allows 5 units per day on code H0015 Allows 4 units per day on code 99429 when billed with modifier EP Code 90911 to be exempt from MFD Code T1019 is allowed 96 units per day
<b>New Jersey</b>	Due to State Regulations, New Jersey Medicaid has exceptions to the following codes: 96101 has a daily limit of 6 units per day 96102 has a daily limit of 6 units per day 96103 has a daily limit of 6 units per day 96116 has a daily limit of 6 units per day 96118 has a daily limit of 6 units per day 96120 has a daily limit of 6 units per day 96125 has a daily limit of 6 units per day 96127 has a daily limit of 1 unit per day 96110 has a daily limit of 1 unit per day 96150 has a daily limit of 6 units per day 96151 has a daily limit of 4 units per day 96152 has a daily limit of 4 units per day 96153 has a daily limit of 4 units per day 96154 has a daily limit of 4 units per day H0035 has a daily limit of 5 units per day T1019 has a daily limit of 96 units per day S8990 has a daily limit of 8 units per day H0019 when billed with modifier U3 is exempt from unit limits 97532 when billed with modifier U4 & U5 is exempt from unit limits 97535 & 97110 when billed with modifiers U2, U3, U4 or U5 is exempt from unit limits B4220, B4222. B4224 and S9343 is exempt from unit limits
<b>New York</b>	New York has an exception for the following codes to be exempt from MFD: J7175, J7178, J7179, J7180, J7181, J7182, J7183, J7185, J7186, J7187, J7188, J7189, J7190, J7191, J7192, J7193, J7194, J7195, J7198, J7199, J7200, J7201, J7202, J7205, J7207 and J7209 Due to State Regulations, there is no daily limit for H0031 and H0032 Due to State requirements, CPT code 97530 is allowed 8 units per day Due to State requirements, HCPCS code A4575 is allowed 16 units per day H0004 has a daily limit of 4 per day H2011 has a daily limit of 8 per day H0036 has a daily limit of 6 per day H2017 has a daily limit of 8 per day H0038 has a daily limit of 8 per day H2014 has a daily limit of 24 per day T2015 has a daily limit of 2 per day H2015 has a daily limit of 12 per day H2023 has a daily limit of 12 per day S5150 has a daily limit of 16 per day T1019 has a daily limit of 96 per day 0403T has a daily limit of 2 per day
<b>North Carolina</b>	North Carolina Medicaid allows the following unit limits per day: 96040 - 3 units per day 97802 - 4 units per day 97803 - 4 units per day 95017 - 30 units per day



	<p>95071 -1 unit per day            95079 - 2 units per day            95180 - 12 units per day            95144 - 10 units per day            95145 - 1 unit per day            95146 - 1 unit per day            95147 - 1 unit per day            95148 - 1 unit per day            95149 - 1 unit per day            95170 - 1 unit per day            Code 99509 with HA or HB modifier: 1 unit is equal to 15 minutes and should not have a 1 per day max. Daily max is 96 units.</p>
<b>Ohio</b>	<p>Ohio Medicaid allows the following unit limits:            H0005 and H0006 – 96 units per day            H0014 - 1 unit per day            H0038 - 16 units per day            H2012 - 2 units per day            J0571-J0575- based on milligrams administered (i.e. 12 mg administered, 4 units submitted using J0572).            T1016 is exempt from MFD limits            T1019 is allowed 96 units per day            Ohio MME has an exception from CMS for codes 90792, 90863, H0001, H0007, H0016, and H0020 when billed in a place of service 53 to be exempt from MUE/MFD edit limits.</p>
<b>Pennsylvania</b>	<p>PA has an exception from CMS for the following codes:            Allows 2 units per day on code T1028 when reported with Modifier HD            Allows 96 units per day on code T1019</p>
<b>Rhode Island</b>	<p>Rhode Island has an exception from CMS for code S9446 to be exempt from MUE edit limits.            Rhode Island has an exception for code 99211 for Behavioral Health.            Rhode Island Medicaid allows the following unit limits:            S9445 – 20 units per day            S9446 – 6 units per day            T1016 – 16 units per day            T1024 – 20 units per day</p>
<b>Tennessee</b>	<p>Tennessee has an exception for codes G9004, G9005, G9006, G9007, G9010, and G9011 when billed with modifiers UB or UA.            HCPCS code H0031 and H0032 allows up to 96 units per day            Code 95165 is exempt from MFD limits            Code 95170 allows up to 40 units per day when billed with modifier U1            Code T1019 allows 96 units per day</p>
<b>Texas</b>	<p>Per Texas Medicaid:</p> <ul style="list-style-type: none"> <li>• Providers are required to bill additional vaccine administration codes on separate lines with only 1 unit</li> <li>• 81099, 82803, 82948, 84999, 90460, 90461, 90472, 90474, A4281, A4282, A4284, A4286, H0005 and H0020 are exempt from MFD.</li> <li>• 82642, 83722, 86790, 86794, 87015, 87046, 87071, 87075, 87076, 87077, 87081, 87088, 87101, 87102, 87106, 87107, 87140, 87147, 87149, 87150, 87152, 87153, 87181, 87184, 87185, 87186, 87188, 87190, 87206, 87209, 87210, 87252, 87254, 87300, 87634, 87801, 87809, 87899, 87904, 97799 and A4396 allows 1 unit per day.</li> <li>• 87798, 97535 and 97537 allow up to 3 units per day each</li> <li>• A0420 and S5101 allows up to 2 units per day</li> <li>• A4253 and A9275 allow up to a combined total of 2 units per month for insulin dependent diabetics and a combined total of 1 unit per month for noninsulin dependent diabetics.</li> <li>• H2014 allows up to 16 units which equals up to 4 hours.</li> </ul>

	<ul style="list-style-type: none"> <li>• S5151 allows up to 24 units when billed with modifier U3, U7, UC, US or 99</li> <li>• T1019 allows up to 96 units per day</li> <li>• T1026 allows up to 4 units per day</li> <li>• T1000 allows up to 96 units per day</li> <li>• Texas allows 1 unit per day for HCPCS Code H0033</li> </ul>
<b>Virginia</b>	<p>VA has an exception for the following codes:          Allows 1 unit per day for codes H0006, H0014, H0015 and H2015          Allows 3 units per day for codes H2016 and H2017          Allows 5 units per day for code H0032          Allows 6 units per day for codes G0151, G0152, G0153, G0495, T1015, T1024, T1026 and T1027          Allows 12 units per day for code H2019          Allows 16 units per day for codes H0024, H0025, T1012 and S9445          Allows 24 units per day for codes G0493, G0494, H0004, H0005, S5126, S5150, T1000, T1001, T1002, T1003, T1005, T1019, T1023, T1030 and T1031          Allows 48 units per day for code H2021          VA is exempt from MFD limits for code(s) S0109</p>
<b>Washington</b>	<p>Per State regulations, Washington Medicaid has exceptions to the following codes:          Code 95870 allows 5 units per day          Code A4349 allows 2 units per day          Codes S9430 &amp; H0003 does not impose a daily limit          Codes H0010, H0011 &amp; H0016 do not impose a daily limit for Behavioral Health          Code H0020 allows 2 units per day          Code T1019 allows 96 units per day          Codes J0570, J0572, J0573, J0574, J0575, and J2310 does not impose any daily limits or quantity and dose limitations as of 07/01/2021          The following COVID19 codes do not impose a daily limit:          98966, 98967, 98968, 99001, 99421, 99422, 99423, 99441, 99442, 99443, 99451, G2012</p>
<b>Wisconsin</b>	<p>Per State regulations, Wisconsin Medicaid has exceptions to the following codes:          Allows 2 units per day on code 99082          Allows 4 units per day on code T1006          Allows 24 units per day on code H0022          Allows 96 units per day on code H0005          Allows 96 units per day on code T1019          There are no limitations on code A4363 as of 01/01/2021          Wisconsin Department of Health Services publish separate unit limits specific to Wisconsin Medicaid for specific physical, occupational, and speech therapy services. Please refer to the C&amp;S Physical Medicine &amp; Rehabilitation: Maximum Combined Frequency per Day Policy.</p>

### Questions and Answers

<b>1</b>	<p><b>Q:</b> Why do you exclude network home health services and supplies/home health agencies, anesthesia management, and ambulance providers from this policy?</p> <p><b>A:</b> There are many contracts specific to these physicians and other qualified health care professionals that permit codes to be used in a different manner than intended by CPT and HCPCS, which make the application of this policy unworkable. Billing practices may also dictate that the units field is used to report something other than how many times a service was performed (i.e. mileage), which again may make the application of this policy</p>
----------	--

	unworkable. These providers were excluded until contract language and/or billing practices can be reviewed and changed.
<b>2</b>	<p><b>Q:</b> When the frequency of a billed service on a date of service is greater than the established MFD value, will there be additional reimbursement?</p> <p><b>A:</b> When a physician or other qualified healthcare professional reports units accurately, yet those units exceed the established MFD value, an appropriate modifier such as 59, 76, 91, XE, XS, or XU may be utilized. The MFD value is a threshold set solely to avoid overpayment due to billing and data entry errors. UnitedHealthcare Community Plan intends to reimburse all services performed and reported with proper coding in accordance with its reimbursement policies and benefit or provider contracts. Medical records do not need to be submitted for the purposes of this policy, unless the processed claim is being submitted on appeal. 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 and subject to additional UnitedHealthcare Community Plan reimbursement policies.</p>
<b>3</b>	<p><b>Q:</b> Why has UnitedHealthcare Community Plan set the MFD value at 1 for bilateral procedures?</p> <p><b>A:</b> UnitedHealthcare Community Plan has set the MFD value for most bilateral procedures at 1. The preferred method of billing a bilateral eligible procedure is with 1 unit on one claim line with modifier 50. Modifier 50 indicates that one procedure was performed bilaterally. Bilateral eligible procedures may also be billed on two lines with 1 unit each and modifiers RT and LT. There are some codes that describe more than one anatomical site or vertebral level that can be treated bilaterally where the MFD value may be more than 1.</p>
<b>4</b>	<p><b>Q:</b> Would the MFD value for bilateral procedures remain at 1 unit if it is possible to perform these procedures more than once per day?</p> <p><b>A:</b> If the bilateral procedure is provided more than once per day, modifiers 59, 76, XE, XS, or XU may be appropriate to bill depending on the circumstance. Additional reimbursement will be considered with the use of these modifiers.</p>
<b>5</b>	<p><b>Q:</b> Would the MFD value for hand or foot bilateral procedures remain at 1 unit if it is possible to perform the procedure on multiple digits such as fingers or toes?</p> <p><b>A:</b> The MFD value would remain at 1 unit, however, HCPCS modifiers FA or F1-9 may be used to report specific fingers; TA or T1-9 may be used to report specific toes.</p>
<b>6</b>	<p><b>Q:</b> Will UnitedHealthcare Community Plan allow more than 1 unit for a CPT or HCPCS code with “per diem” or “per day” in the code description?</p> <p><b>A:</b> UnitedHealthcare will allow 1 unit of a procedure code with “per diem” or “per day” or other verbiage describing once daily in the code description. There are no modifiers that will override the MFD value.</p> <p>For example, if a patient requires home infusion antibiotic therapy twice daily, it would be more appropriate to report 1 unit of HCPCS code S9501 rather than 2 units of S9500. The MFD 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.</p> <ul style="list-style-type: none"> <li>• S9500 Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</li> <li>• S9501 Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem.</li> </ul>
<b>7</b>	<p><b>Q:</b> What is an example of a code that is limited because of anatomical or clinical reasons?</p> <p><b>A:</b> An appendectomy would be set at the MFD value of 1 unit because a person only has one appendix.</p>
<b>8</b>	<p><b>Q:</b> How should 90460 and/or 90461 be reported when multiple immunizations <u>with</u> face-to-face counseling are performed on the same date of service? For example, if the physician or other qualified health care professional</p>



administers immunizations for a 2-month-old infant on the same date of service according to the current immunization schedule, how should the following immunizations be reported?

Immunization	Components	CPT Code
DtaP intramuscular administration	3	90460
		90461 x 2
Rotavirus oral administration	1	90460
Hepatitis B and Hemophilus influenza b intramuscular administration	2	90460
		90461
Poliovirus intramuscular administration	1	90460
Pneumococcal conjugate vaccine	1	90460

**A:** Coding practices may vary by physician or other qualified healthcare professional offices. It is appropriate to report the immunization administration of the first and additional vaccine/toxoid component with face-to-face counseling on one line with multiple units and a link to all associated ICD-10-CM codes or report each component on a separate line. In the example above, the claim could be reported as 90460 with 5 units on one line and 90461 with 3 units on a separate line with the associated ICD-10-CM diagnoses linked to each line.

It is also appropriate to report the administration of each vaccine component on separate lines; e.g. reporting 5 lines for 90460 with 1 unit each and 3 lines for 90461 with 1 unit each. However, when reporting the same CPT or HCPCS code on multiple lines and/or on separate claims, the additional claim line(s) reported with the same procedure code may be denied as a duplicate service.

**9** **Q:** How are MFD values for immunization administration CPT codes 90472 and 90474 determined?  
**A:** UnitedHealthcare Community Plan follows the recommendations from the Center for Disease Control's (CDC) Advisory Committee on Immunization Practices (ACIP) to set the MFD value for additional immunization administration codes.

**10** **Q:** What are examples of procedures or services where the "description/verbiage" clearly indicates the number of units performed on a single date of service?  
**A:** Examples include, among others, services that include "single lesion," "XX or more lesions," or "per date of service" in the code description should be reported with 1 unit of service.






**11** **Q:** Why are many new CPT and HCPCS codes set at an MFD value of 100?  
**A:** There is no 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 claims data is available on a code, the MFD value will be established.

**12** **Q:** What is an example of determining the MFD value at the 100<sup>th</sup> percentile unless the 100<sup>th</sup> percentile exceeds the 98<sup>th</sup> percentile by greater than a factor of 4?  
**A:** Statistical calculation: (A) x 4 = (C); if (B) is greater than (C), then the 98<sup>th</sup> percentile is set for the MFD value. If (B) is less than or equal to (C), then the 100<sup>th</sup> percentile is set for the MFD value. Here are two examples of determining MFD values based on a factor of 4.

Code	(A) Units @ 98 <sup>th</sup>	(B) Units @ 100 <sup>th</sup>	(C) Factor of 4	Set MFD at:
86902	14	27	56	27
E0676	2	30	8	2

<b>13</b>	<p><b>Q:</b> What is an example of a clinical circumstance where UnitedHealthcare Community Plan would assign a specific MFD value?</p> <p><b>A:</b> A4595-Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES). According to standard criteria, the data showed the 98<sup>th</sup> percentile at 10 units and the 100<sup>th</sup> percentile at 72 units. The statistical calculation would have set the MFD value at 10. However, based on the code description allowance of “per month” and subject to the UnitedHealthcare Community Plan Time Span Codes Reimbursement Policy, the MFD value was decreased to one (1).</p>
-----------	--

### Attachments

 <b>UnitedHealthcare Community Plan Maximum Frequency Per Day (MFD) CPT Code Policy List</b>	Designates the maximum frequency per day value assignments for CPT codes.
 <b>UnitedHealthcare Community Plan Maximum Frequency Per Day (MFD) HCPCS Policy List</b>	Designates the maximum frequency per day value assignments for HCPCS codes.
 <b>UnitedHealthcare Community Plan Maximum Frequency Per Day (MFD) Codes Restricting Modifiers LT and RT</b>	Codes that allow up to the MFD value that have "bilateral" or "unilateral or bilateral" in the description or where the concept of laterality does not apply.
 <b>Arizona Maximum Frequency Per Day (MFD) CPT and HCPCS Policy List</b>	Designates the Arizona Medicaid maximum frequency per day value assignment for CPT and HCPCS codes.
 <b>Missouri Maximum Frequency Per Day (MFD) CPT and HCPCS Policy List</b>	Designates the maximum frequency per day value assignment for CPT and HCPCS codes.

### Resources

<p>Individual state Medicaid regulations, manuals &amp; fee schedules</p> <p>American Medical Association, <i>Current Procedural Terminology (CPT®) Professional Edition</i> and associated publications and services</p> <p>Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services</p>
--

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

History	
<b>9/12/2021</b>	Policy Version Change State Exception Section: Updated WA exceptions
<b>8/30/2021</b>	Policy Version Change Policy List Change: MFD CPT, HCPCS, Codes Restricting Modifiers LT and RT updated and Arizona Maximum Frequency Per Day (MFD) CPT and HCPCS Policy List
<b>8/23/2021</b>	Policy Version Change State Exception Section: Updated NC exceptions
<b>8/15/2021</b>	Policy Version Change State Exception Section: Updated NC exceptions
<b>8/13/2021</b>	Policy Version Change State Exception Section: Updated NC exceptions
<b>8/8/2021</b>	Policy Version Change Policy List Change: MFD CPT, HCPCS and Codes Restricting Modifiers LT and RT and Arizona Maximum Frequency Per Day (MFD) CPT and HCPCS Policy List State Exception Section: Updated VA exceptions
<b>7/25/2021</b>	Policy Version Change Policy List Change: MFD HCPCS and Codes Restricting Modifiers LT and RT State Exception Section: Updated WA exceptions
<b>7/18/2021</b>	Policy Version Change State Exception Section: Updated VA exceptions
<b>7/12/2021</b>	Policy Version Change Policy List Change: MFD CPT, HCPCS, Codes Restricting Modifiers LT and RT updated and Arizona Maximum Frequency Per Day (MFD) CPT and HCPCS Policy List History Prior to 7/12/2019 Archived
<b>6/27/2021</b>	Policy Version Change Policy List Change: MFD CPT, HCPCS, Codes Restricting Modifiers LT and RT updated and Arizona Maximum Frequency Per Day (MFD) CPT and HCPCS Policy List History Prior to 6/27/2019 Archived
<b>6/13/2021</b>	Policy Version Change State Exception Section: Updated NC State Exception verbiage History Prior to 6/13/2019 Archived
<b>05/23/2021</b>	Policy Version Change Policy List Change: MFD CPT, HCPCS and Codes Restricting Modifiers LT and RT updated State Exceptions: Updated North Carolina Exceptions
<b>4/30/2021</b>	Policy Version Change and Anniversary Update Policy Attachments List Change: Added Arizona MFD CPT and HCPCS History Section: Entries prior to 4/30/2019 archived
<b>4/25/2021</b>	Policy Version Change State Exceptions section: Updated Ohio exceptions
<b>4/1/2021</b>	Policy Version Change Policy List Change: MFD CPT, HCPCS and Codes Restricting Modifiers LT and RT updated

<b>3/21/2021</b>	Policy Version Change State Exceptions Section: Updated Wisconsin State Exceptions
<b>2/28/2021</b>	Policy Version Change Policy List Change: HCPCS, Codes Restricting Modifiers LT and RT
<b>1/17/2021</b>	Policy Version Change Policy Attachments List Change: Removed Arizona MFD CPT and HCPCS
<b>1/1/2021</b>	Policy Version Change Policy List Change: MFD CPT, HCPCS, Codes Restricting Modifiers LT and RT and Arizona MFD CPT and HCPCS History Prior to 1/1/2019 Archived
<b>12/13/2020</b>	Policy Version Change Policy List Change: HCPCS and Codes Restricting Modifiers LT and RT updated
<b>12/06/2020</b>	Policy Version Change Policy List Change: Arizona Maximum Frequency Per Day CPT and HCPCS Policy List
<b>11/29/2020</b>	Policy Version Change Policy List Change: HCPCS and Codes Restricting Modifiers LT and RT updated
<b>11/22/2020</b>	Policy Version Change Policy List Change: MFD CPT and Codes Restricting Modifiers LT and RT
<b>10/25/2020</b>	Policy Version Change Policy List Change: MFD CPT, Codes Restricting Modifiers LT and RT and Arizona MFD CPT and HCPCS
<b>10/11/2020</b>	Policy Version Change Policy List Change: MFD CPT State Exceptions section: Updated Hawaii and Texas
<b>9/27/2020</b>	Policy Version Change Policy List Change: MFD CPT, HCPCS and Codes Restricting Modifiers LT and RT updated State Exceptions section: Updated Rhode Island exceptions
<b>9/20/2020</b>	Policy Version Change Policy List Change: MFD CPT and Codes Restricting Modifiers LT and RT and Arizona Maximum Frequency Per Day CPT and HCPCS Policy List
<b>8/31/2020</b>	Policy Version Change Policy List Change: MFD HCPCS
<b>8/24/2020</b>	Policy Version Change Policy List Change: MFD CPT and Codes Restricting Modifiers LT and RT
<b>7/20/2020</b>	Policy Version Change Policy List Change: MFD HCPCS
<b>7/13/2020</b>	Policy Version Change Policy List Change: MFD CPT and Codes Restricting Modifiers LT and RT State Exceptions section: Updated Texas exceptions and deleted Iowa exceptions History prior to 7/1/2018 archived
<b>6/29/2020</b>	Policy Version Change Policy List Change: MFD CPT, HCPCS, and Codes Restricting Modifiers LT and RT Questions and Answers: Updated Questions 7 and 10
<b>6/15/2020</b>	Policy Version Change

	Policy List Change: Arizona MFD CPT and HCPCS, State Exceptions section: Updated New Jersey exceptions
<b>6/8/2020</b>	Policy Version Change Policy List Change: MFD CPT
<b>6/1/2020</b>	Policy Version Change State Exceptions section: Updated Kansas exceptions
<b>5/25/2020</b>	Policy Version Change State Exceptions section: Updated Texas exceptions
<b>5/1/2020</b>	Annual Anniversary Date and Version Update Policy List Change: Arizona Maximum Frequency Per Day (MFD) CPT and HCPCS Questions and Answers: Updated Question 10
<b>4/21/2020</b>	Policy Version Change Policy List Change: MFD CPT, HCPCS, and Codes Restricting Modifiers LT and RT
<b>4/19/2020</b>	Policy Version Change State Exceptions section: Updated Washington exceptions
<b>4/6/2020</b>	Policy Version Change Policy List Changes: Arizona Maximum Frequency Per Day (MFD) CPT and HCPCS, MFD HCPCS, Codes Restricting Modifiers LT and RT updated
<b>3/29/2020</b>	Policy Version Change State Exceptions section: Updated Florida exceptions Policy List Change: MFD CPT, MFD HCPCS, Codes Restricting Modifiers LT and RT updated Modifier section: Definitions removed Anatomic Modifier section: Definitions removed History Section: Entries prior to 3/29/18 archived
<b>03/17/2020</b>	Policy Version Change Policy List Change: MFD CPT, MFD HCPCS, Codes Restricting Modifiers LT and RT updated State exceptions section: Removed reference to Louisiana Removed all files and references to Louisiana contained in the body of the policy, information has been moved to the "Louisiana Only" policy
<b>02/25/2020</b>	Policy Version Change State exceptions section: Updated Tennessee exception, replaced "GD" modifier with "U1"
<b>02/24/2020</b>	Policy Version Change Policy List Change: Updated Missouri Maximum Frequency Per Day (MFD) CPT and HCPCS Policy List
<b>02/16/2020</b>	Policy Version Change State Exceptions: Updated Delaware, Kansas, Maryland, New Mexico, New York, Pennsylvania, Texas, Virginia
<b>01/01/2020</b>	Policy Version Change State Exceptions: Updated Kansas and Washington Policy List Change: updated Missouri Maximum Frequency Per Day (MFD) CPT and HCPCS Policy List, MFD CPT Policy List and Codes Restricting Modifiers LT and RT Policy list History prior to 1/1/2018 archived
<b>12/1/2019</b>	State Exceptions: updated Texas
<b>11/17/2019</b>	State Exceptions: updated multiple states with HCPCS Code T1019
<b>9/22/2019</b>	Policy Version Change State Exceptions: updated Nebraska, New York and Texas



	Policy List Change: updated Missouri Maximum Frequency Per Day (MFD) CPT and HCPCS Policy List, MFD CPT, HCPCS and Codes Restricting Modifiers LT and RT Policy lists
<b>9/6/2019</b>	Policy List Change: updated Arizona MFD CPT and HCPC Policy list
<b>8/25/2019</b>	State Exceptions: updated Tennessee
<b>8/11/2019</b>	State Exceptions: updated Virginia Policy List Change: updated Arizona MFD CPT and HCPC Policy list
<b>1/6/2006</b>	Policy implemented by UnitedHealthcare Community & State

[Back to Top](#)