

Maximum Units Policy

Applies to the following Tufts Health Plan products:

- Tufts Health Plan Commercial (including Tufts Health Freedom Plan)¹
- Tufts Medicare Preferred HMO (a Medicare Advantage product)²
- Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)²

Applies to the following Tufts Health Public Plans products:

- Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)
- Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- Tufts Health RITogether (a Rhode Island Medicaid Plan)
- Tufts Health Unify (OneCare Plan; a dual-eligible product)

The following policy applies to Tufts Health Plan contracting providers.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the [Professional Services and Facilities Payment Policy](#).

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan assigns a maximum number of units allowed for procedure codes, as described below.

Lifetime Maximums

Tufts Health Plan assigns a maximum number of units to select procedure codes that may be billed within a member's lifetime.

Commercial

Maximum number of units per provider group per single date of service

Tufts Health Plan assigns a maximum number of units that may be billed for a single date of service by the same **provider or provider group**. If the number of units billed exceeds the maximum number of units allowed for the service, Tufts Health Plan will compensate only the maximum number of units allowed. The unit(s) assigned is subject to change and may be subject to adjustment based on the diagnosis associated with the procedure code submitted and is not a guarantee of payment.

Example

Procedure code 25530 (closed treatment of ulnar bone fracture) allows two units, as there are only two ulnar bones in the body. If three or more units are billed, the maximum number of units will be reduced to two and compensated accordingly.

Annual Maximums

Tufts Health Plan has assigned a maximum number of units to select procedure codes that may be billed within a 12-month period by the same **provider or provider group**.

Tufts Health Public Plans and Senior Products

Maximum number of units per member per single date of service

Tufts Health Plan assigns a maximum number of units that may be billed for a single date of service **per member**. If the number of units billed exceeds the maximum number of units allowed for the service, Tufts Health Plan will compensate only the maximum number of units allowed. The unit(s) assigned is

¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.

² Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

subject to change and may be subject to adjustment based on the diagnosis associated with the procedure code submitted and is not a guarantee of payment.

Annual Maximums

Tufts Health Plan has assigned a maximum number of units to select procedure codes that may be billed within a 12-month period **per member**.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider [portal](#) or by contacting [Provider Services](#).

Note: There is no member responsibility for covered services for Tufts Health Plan SCO, Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry standard coding guidelines. Refer to current coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the [Professional Services and Facilities Payment Policy](#).

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

If there is a medically necessary reason to bill in excess of the maximum units allowed by Tufts Health Plan for the procedure code, the provider can submit an appeal through the Provider Payment Dispute process for [Commercial](#), [Senior Products](#) and [Tufts Health Public Plans](#). The provider's Explanation of Payment (EOP) and Electronic Remittance Advice (ERA) will reflect the number of units that have been compensated.

Adjustments Process

When a provider bills a certain number of units that exceeds the assigned amount allowed for that procedure, the total number of units will be adjusted to the assigned allowed amount and the excess units will be denied. Tufts Health Plan notifies providers via an explanation of payment (EOP) or 835 file. The EOP identifies the adjusted amount, member name, member ID number, claim number, provider name, and correct payment amount.

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable network contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For additional information, refer to the [Professional Services and Facilities Payment Policy](#).

Daily Max Units Regardless of Modifier

Tufts Health Plan will not routinely compensate excess units when any provider bills more than one unit of service for certain procedures, regardless of appended modifier and with the same revenue code.

DOCUMENT HISTORY

- August 2020: Combined with Tufts Health Public Plans Maximum Units Reduction Payment Policy
- June 2018: Template updates
- November 2017: Added edits for daily max units for dates of service on or after January 1, 2018
- January 2017: Template updates
- September 2015: Template conversion, template updates

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's [audit policies](#), refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLinkSM for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.