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)
☑ Tufts Health Plan Senior Care Options (SCO) (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 all procedure codes, as described below.

Procedure Code Maximums
Tufts Health Plan has assigned 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.

Lifetime Maximums
Tufts Health Plan has assigned a maximum number of units to select procedure codes that may be billed within a member’s lifetime.

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 website or by contacting Commercial Provider Services or Senior Products Provider Relations.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO members.

COMPENSATION/REIMBURSEMENT INFORMATION
If there is a medically necessary reason to bill in excess of the maximum units allowed by the Plan for the procedure code, the provider can submit a Compensation/Reimbursement Appeal through the Provider Payment Dispute process. The provider’s Explanation of Payment (EOP) and Electronic Remittance Advice (ERA) will reflect the number of units that have been compensated.

Daily Max Units Regardless of Modifier²
Effective for dates of service on or after January 1, 2018, 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.

---

¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.
DOCUMENT HISTORY

- 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
- October 2014: Policy reviewed; condensed and reformatted information for clarity
- September 2013: Template conversion
- August 2013: Policy reviewed; template updates.
- April 2012: Template updates
- March 2012: Updated CareLink disclaimer language
- October 2011: Template updates, no content changes
- October 2010: Added: Unit values assigned may be subject to adjustment based on the diagnosis associated with the procedure code submitted.
- August 2010: Revised policy to include Tufts Health Plan Medicare Preferred
- February 2008: Revised general benefit information with self-service channels information.

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.