Commercial Reimbursement Policy

Subject: **Frequency Editing - Professional**	
Policy Number: **C-08012**	Policy Section: **Coding**
Last Approval Date: **04/24/2024**	Effective Date: **10/01/2024**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem member's 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, as well as to the member's state of residence.

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 Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

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

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

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Anthem 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, unless provider, state, federal contracts, and/or requirements indicate otherwise.

In addition to using claims processing logic to determine when the use of multiple units is appropriate, Anthem also uses the nomenclature for a particular Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS Level II) code, the Centers for Medicare & Medicaid Services (CMS's) Medically Unlikely Edits (MUEs) designation, industry standards, or the ability to clinically perform or report a specific service more than one time on a

single date of service or within a specific date span per member, per provider in making these determinations.

I. The factors listed below identifies when a procedure will be limited in units, or number of times a code is eligible for reimbursement on a single date of service:
   - The description of a procedure code includes the word(s) “bilateral” or “unilateral or bilateral”
   - A procedure code description specifies “unilateral” and there is another CPT© code for the bilateral service or another add-on code for additional services (the unilateral CPT© code cannot be submitted more than once on a single date of service)
   - The description of a procedure code includes a specific time frame
   - The parenthetical statement associated with the procedure code includes a specific time frame
   - The description of a procedure code implies multiplicity
   - The total number of times it is clinically possible or clinically reasonable to perform a given procedure on a single date of service is limited
   - In some circumstances a RT/LT or site specific modifier will allow a code to process when used more than once, since these modifiers will identify the specific side or digit when more than one site is being treated or evaluated
   - A procedure code is reported more than one time, but typically is not performed more than once on a single date of service

II. When a procedure is submitted with multiple units, and only a single unit is acceptable, reimbursement will be based on only one unit. Modifiers will not override this edit.

III. Anthem will apply all unit/frequency edits pre-adjudication, using both the unit field and multiple submissions of line items.

IV. Anthem will apply a frequency edit, when applicable, to a base code which has a related add-on code listed in CPT Appendix D. Since the related add-on code(s) describes a phrase such as “each additional” or “list separately in addition to the primary procedure,” the base code is eligible for reimbursement only once per date of service.

V. Anthem will apply frequency edits across dates of service for certain codes. This edit will use claim lines processed in history that have previous, current, and subsequent dates of service to accumulate and apply this type of frequency limit.

VI. Anthem will apply frequency maximums per date and /or per date span, which may be based on CMS’s MUEs, industry standards, and/or code description.

VII. Anthem will apply frequency maximums per date and/or per date span when procedures are within the same service grouping.

VIII. Anthem will apply unit maximums to drugs that may be based on manufacturer’s guidelines, U.S. Food and Drug Administration (FDA) approval, and/or code description.

*In certain circumstances, the frequency limit will be applied for the same member, same date of service, across providers. See Related Coding list for reference.

Note**:** Maximum units per date may be based on claims data analysis.

Anthem has customized unit/frequency logic for the procedure codes listed in the attachments below.

Services reported in excess of these restrictions are not eligible for reimbursement even when reported with an override modifier. The inclusion or exclusion of a specific code does not indicate eligibility for coverage under all circumstances.

Related Coding

Code	Description
CPT Maximum Frequency	CPT Maximum Frequency
HCPCS Maximum Frequency	HCPCS Maximum Frequency

Policy History

05/24/2024	Review approved 04/24/2024 and effective 10/01/2024: updated CPT and HCPCS code lists. CPT Codes: • Removed 36415, 36416 and added to Laboratory and Venipuncture C-10001 • Removed 96158-96159, 96164-96165 and added to Health and Behavioral Assessment/Intervention C-11003 • Deleted codes 76942, 77002, 77003, 77012, 77021, 77338, 77600, 77605, 80320-80377, 81479, 86160, 87483, 87491, 87591, 88305, 87529, 90378, 92250, 92273, 92274, 92326, 93325, 95925, 95926, 95938, 95927, 95928, 95929, 95939, 96900, 97012, 97016, 97018, 97022, 97024, 97026, 97028, 93792, 93793 HCPCS Codes • Remove S9529 and added to Laboratory and Venipuncture C-10001 • Remove G0480, G0481, G0482, and G0483 and added to Drug Screen Testing-Professional C-12004 • Remove C9257, G0480, G0481, G0482, G0483 • Added A4238, A4239, A6520-A6529, A6552-A6589, A6593-A6610, Q0509 • Updated A4224 to 13 per 86 days
05/19/2023	Review approved 05/19/2023 and effective 10/01/2023: removed *J0129, J0585, J0717, J0897, J1453, J1560, J1750, J2353, J2469, J2505, J2507, J2800, J3357, J3489, J7312, J7320, J7321, J7323, J7324, J7326, J7322, J7325, J9030, J9351, J9047, J9202, J9217, J9355, J9356 and J9395 codes from HCPCS Maximum Frequency Per Day code list*
01/30/2023	Review approved: removed *J0586*
08/24/2022	Review approved: removed *J2357*
07/23/2021	Review approved and effective 07/23/2021: • Updated G0249 to 3 per 84 days to match CUMG • Updated G0480-G0483 to 24 per 365 days to match CUMG • Removed *deleted code 92399* • Added G2066 • Updated J9351 limit to 120 units to match the Unit Freq policy
09/15/2020	Review approved and effective 09/15/2020: minor administrative updates; removed code list from related coding section attached as separate document

	• Removed deleted codes 92275, 99363, 99364 and J9031 • Added new codes; 92273, 92274, 93792, 93793 and J9030 effective 01/01/2020
07/13/2020	Review approved and effective 12/01/2020: added Psychiatric Diagnostic Evaluation codes 90791 and 90792. Added limitation of 1 per 365 days for ages 21 and over; and 2 per 365 days for ages under 21.
06/24/2020	Review approved and effective 12/01/2020: • Updated G0416 report with 1 unit when also reporting 88305 with greater than 9 units • Removed sleep study verbiage; moved to Sleep Studies reimbursement policy • Removed Injection and Infusion Administration & Related Services and Supplies verbiage; moved to the Injection and Infusion Administration & Related Services and Supplies policy • Updated 96401 • Removed deleted codes 96152-96155 • Added new codes 96158, 96159, 96164 and 96165
06/21/2019	Review approved and effective 11/01/2019: policy language updated to indicate that maximum units per day may be based on claims data analysis.
06/01/2019	Updated policy template: removed description section and added definition section
03/28/2019	Review approved and effective: Updated Policy language updated policy language in #6 to add “industry standards, and/or code description” • Added G0482-G0483 limit 1 per date of service and 18 per 365 days. • Added 81528 limit 1 per 3 years
11/16/2018	Review approved and effective: • Updated A4253 to 22 per 86 days • Updated A4259 to 11 per 86 days
09/07/2018	Review approved and effective; updated 95165 to 150
04/20/2018	Review approved and effective: added parenthetical statement language in D
12/04/2017	Review approved and effective: removed G0482 and G0483
08/31/2017	Review approved and effective: updated A9276 limit 1 per 3 days
08/01/2017	Revised: Updated G0249 to 3 per 84 days
04/04/2017	Review approved and effective • Updated A4230, A4231, A4232, A4244, A4245, A4250, A4253, A4259 to 86 days • Removed deleted codes G0477-G0479 • Added V5267 and V5298 limit 2 per date of service (1 for each ear)
02/07/2017	Review approved and effective: added codes that have frequency limit of 1 that modifiers will not override limit: • Updated 87483 that modifiers will not override • Updated 95925, 95926, 95938, 95927, 95928, 95929, 95939 that modifiers will not override • Updated 96900 that modifiers will not override
01/03/2017	Review approved and effective:

	• Added C9257 limit of 10 units per date of service with no modifier override (5 per eye) • Added J7320 limit 50 units per date of service • Added J7322 limit 48 units per date of service
12/06/2016	Review approved and effective: • Added E0602, E0603, and E0604 limit 1 per date of service • Updated J1750 to 40 units per date of service with no modifier override.
11/01/2016	Review approved and effective: Updated notes for bullets #6 and #7 • Added 87491 and 87591 limit of 3 per date of service • Added S9140 and S9141 limit of 1 per date of service
09/06/2016	Review approved and effective: Added language to Limit CPT/HCPCS code(s) (CODES WITH CMS MAI OF 2) to1 per date of service OR XX Units per DOS and no modifier override. • Updated 91065 limit 1 per date of service when no modifier is billed • Updated H0020 and H0022 to 1 per date of service when billed by the same provider and allow no modifier override. • Added 49185 limit of 1 per day with no modifier override • Updated J9047 to 150 units per date of service with no modifier override with an effective date of 7/15/16. • Removed 95782, 95783, 95807, 95808, 95810, and 95811 limit 1 per 60 days
05/03/2016	Review approved and effective: minor language updates, removed DME from bullet #6— • Added 86160 limit of 4 per date of service • Updated the descriptions of the attended sleep studies
04/05/2016	Review approved and effective: Minor language revisions • Updated professional services for allergen immunotherapy to 130 doses per 365 days • Added 95782, 95783, 95807, 95808, 95810, and 95811 limit of 1 per 60 days
02/02/2016	Review approved and effective: updated A4253 to 13 boxes per 90 days
01/05/2016	Review approved and effective: • Added 0403T limit of 24 per 365 days new code for 1/1/16 • Removed G0431 and G0434- codes deleted 1/1/16 • Added G0477-G0483 limit of 1 per date of service • Updated G0480-G0483 limit to 18 per 365 days • Updated J0585 limit to 600
12/01/2015	Review approved and effective: • Added 92275 and 92326 limit 1 per date of service • Added J3357 limit of 90 units per 28 days
10/06/2015	Review approved and effective: added bullet #8 in policy section regarding drug limitations based on manufacturers or FDA approval • Added 11720 and 11721 limit 1 per 60 days • Added S9123 and S9124 limit of 24 per date
08/04/2015	Review approved and effective: updated 80320-80377 and 83992 to 18 units in a 365-day period
07/07/2015	Review approved and effective: added 80320-80377 and 83992 limit 1

06/02/2015	Review approved and effective: updated order of #7 code listing, removed "of service" in code table list. • Added 80321-80322, 80324-80337, 80339-80344, 80346-80347, 80350-80352, 80361-80364, 80369-80370, and 80375–80377 limit 1 unit per date of service • Updated 95250-95251 to 1 per 30 days. • Updated the description of J1560 • Added J0696 limit 16 units per date of service • Added J2800 limit 3 units per date of service • Added J7307 limit 1 unit per date of service
04/07/2015	Review approved and effective: • Added 87529 – Limit 1 per date of service • Updated 96401 with "per drug"
11/04/2014	Review approved and effective: • Added A4556 per pair limit of 2 per 30 days • Added A4557 per pair limit of 4 units per 365 days
06/03/2014	Review approved and effective: • Added 88305 limit 9 units per date of service • Added 96516 limit 120 doses per 365 days • Updated A4253 units to 11 per 90 days
05/06/2014	Review approved and effective: updated Description section with the same language used in bullet #6 under the policy section. • Updated code 36146 to 36416 incorrectly entered • Added 77338 limit of 1 per date of service • Updated 96116 to 5 hours per 365 days
03/04/2014	Review approved and effective: removed brackets from unattended and home sleep studies limits, • Added 96401 limit 1 per date of service when reported for Xolair per injection • Added A6530-A6541, A6545 and A6549, limit of 8 per 365 days for each
02/04/2014	Review approved and effective: updated language in Description section; Policy section bullet #6, moving reference to DME; added bullet #7 apply frequency edit descriptions. Updated column title to Frequency Limit, updated language from 1 per month to 1 per 30 days • Moved 36415, 36416 and S9529 – 1 unit from Lab and Venipuncture policy to code list • Added 81479 -1 per date of service • Update language for 95800, 95801, 95806, G0398, G0399 and G0400 for limitation • Update limit E1812 to 1 per month • Added G0249 limit 3 units in 90 days • Updated A4230 – A4253, and A4259 to x per 90 days • Added A4595 limit 2 per 30 days • Added J9355 limit 95 units per date of service
10/01/2013	Review approved and effective: updated acronyms language; added 96116 - limit 5 per 365 days
03/05/2013	Review approved and effective: added 95800, 95801, 95806, G0398, G0399, G0400, limit 1 per 7

01/08/2013	Review approved and effective: added 90378 -4 units per date of service
01/06/2012	Review approved and effective: • Added 77002, 77003, 77012, 77021, G0431, G0434 1 per date of service • Services billed in excess of these restrictions are not eligible for reimbursement even when billed with an override modifier added: (e.g., modifier 59 or modifier 91).
09/11/2012	Review approved and effective: added language to Coding section "The Health Plan will apply frequency maximums per day and/or per date span (usually based on CMS's MUEs, industry standards, and/or HCPCS description) for Durable Medical Equipment (DME).', added 76942 limit of 1.
07/10/2012	Review approved and effective: added diabetic supplies
05/01/2012	Review approved and effective: added codes to the example in item #4 in the policy section • Added 77600, 77605 limit 1 per DOS; Q4101 limit 44 per DOS; E1812 1 per 27 days
03/06/2012	Review approved and effective: • Added examples to Policy section #2 (90471 and 90473) • Added J7321, J7323, J7324, and J7326 limit of 2 per day • Added 99183 limit of 3 per day
02/10/2012	Review approved and effective; minor language changes • Added 92250
09/13/2011	Review approved and effective: updated language on multiplicity #4, added examples were added to evaluation(s); added 96150-96154 with 8 units
07/12/2011	Review approved and effective; coding section updated: • Removed codes deleted in 2011: J1470-J1550, 93012, and 96014 • Removed J1460 • Added 93293-93296, 93297-93299
07/06/2010	Review approved and effective 8/29/2010: • Updated CPT 96367 to 6 per date of service. • Removed 90951-90966 • Added 96416
05/04/2010	Review approved; The 1st sentence under description was reworded to indicate that it is the Health Plan's claims processing logic. Updated CPT 96367 to 4 units.
05/15/2009	Policy reviewed and effective: updated 2009 CPT codes. Policy heading was reformatted; Policy section #2, #3 were revised and #4 was added, coding section revised, coding grid expanded and reformatted. • Units per date of service: • Replaced 90767 with new code 96367 -1 Occurrence per 3 days of service • Add section with 95250 and 95251-• 1 Occurrence per 90 days of service • Add section with 99363 and 99364 - 1 Occurrence per month • Replaced G0308-G0319 with new codes 90951-90962. • Added 90963-90966, 94014-94016, 94774-94777, E0441-E0444
02/21/2009	Review approved and effective: Editing implemented based on new 2009 codes

12/03/2008	Review approved: reviews completed
10/21/2008	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2024

Definitions

Medically Unlikely Edit (MUE)	Maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.
General Reimbursement Policy Definitions	

Related Policies and Materials

Code and Clinical Editing Guidelines - Professional
Health and Behavior Assessment and Intervention - Professional
Laboratory and Venipuncture Services – Professional and Facility
Modifier Usage – Professional
Modifiers 50 and 51: Multiple and Bilateral Surgery - Professional

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.