



Highmark Blue Cross Blue Shield (Highmark BCBS) partners with Wellpoint companies to administer certain services to Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHPlus), and Essential Plan (EP) members. Please note, this information is specific to the MMC, HARP, CHPlus, and EP programs only.

## Reimbursement Policy

# Maximum Units Per Day

Policy Number: **G-15003**  
Policy Section: **Administration**  
Last Approval Date: **12/02/2025**  
Effective Date: **12/02/2025**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to <https://providerpublic.mybcbswny.com>.

### Policy

The health plan 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 per day, unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

When the number of units assigned to a procedure or service exceeds the daily maximum allowed, the units billed in excess of the maximum per day limit will not be eligible for reimbursement.

When a provider appropriately bills units that exceed the maximum units allowed, documentation must be provided for consideration of reimbursement.

Maximum units per day edits do not affect National Correct Coding Initiative (NCCI) edits. For more information on NCCI edits, please see our Code and Clinical Editing Guidelines reimbursement policy.

Note: The maximum units per day are based on claims data analysis.

### Related Coding

Standard correct coding applies.

## Definitions

- **Maximum Units** - The assigned maximum number of units per day for a procedure or service which may be reported for a single member on a single date of service by the same provider and/or provider group.
- **General Reimbursement Policy Definitions**

## Related Policies and Materials

- Code and Clinical Editing Guidelines
- Documentation Standards for Episodes of Care

## References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract
- State Medicaid

## Policy History

- **12/02/2025** - Review approved and effective: no changes
- **12/19/2023** - Review approved and effective: no changes
- **06/16/2021** - Review approved: no changes
- **11/26/2019** - Review approved: policy language updated; note updated for clarity
- **04/06/2018** - Review approved and effective: policy language updated
- **03/14/2016** - Initial approval 03/14/2016 and effective 01/01/2017

## 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 a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT<sup>®</sup>) 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, we may:

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

- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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.

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