



Applicable To:

- Medicaid – Excludes Kentucky
- Medicare

**Claims Edit Guideline:
Reimbursement (Maximum Edit
Units)**

Policy Number: HS-296

Original Effective Date: 09/17/2015

Revised Date(s): 10/10/2017, 2/1/2018, 4/27/2018

OVERVIEW

This document serves as guidance to ensure that WellCare reimburses physicians and other 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 Clinical Coverage Guidelines (CCGs) and other related guidelines, 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 health care professional.

WellCare 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 WellCare reimbursement policies. This guideline applies whether a physician or other 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 annually.

For the purpose of this policy, the same individual physician or other health care professional is the same individual rendering health care services reporting the same Federal Tax Identification number.

Reimbursement Guidelines and MUE Editing

WellCare will follow the CMS MUE values before any other MFD criteria are 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.

Part I

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

- The service is classified as bilateral (CMS Indicators 1 or 3) on the Centers for Medicare & Medicaid Services (CMS) National Physician Fee Schedule (NPFS) or the term 'bilateral' is included in the code descriptor. For the majority of 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 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.
- 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 WellCare's judgment, the 98th 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.

Reimbursement

The MFD values apply whether a physician or other 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 WellCare 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.

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. WellCare 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 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. 2015A WellCare Plan Codes Restricting Modifiers LT and RT

There may be situations where a physician or other healthcare professional reports units accurately and those units exceed the established MFD value. In such cases, WellCare 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.

Behavioral Health Outpatient Treatment

A Provider may render up to 20 units of 9000 series codes (90832, 90834, 90837, 90846, 90847, 90849, and 90853) and up to 200 units of HCPC services (e.g., H2012, H2017, H2019, T1017) per Member before a prior authorization would be required on an annual basis (365 calendar days). The annual basis is for the benefit year of the Member. Beyond this timeframe, additional medical documentation must be submitted to receive authorization for additional units within the calendar year. Medical documentation may consist of relevant medical records or the completion of the *Outpatient Service Request Form* (available via the secure Provider Portal on www.wellcare.com). Services must be medically necessary and all benefit limits (daily, weekly, monthly and annual) still apply. For applicable codes, please reference the codes below under *Codes for Behavioral Health Outpatient Treatment*. The claim denial process (DN045) for Providers is noted below:

- Provider submits claim that exceeds the allowed max units without an authorization
- Provider receives claim denial (DN045) instructing them to submit clinical documentation for medical necessity review
- Provider follows claims appeal process in their denial notification
- WellCare processes the appeal and provides notification of the outcome of the medical necessity review via fax
- WellCare reprocesses the claim for any days/units/visits that were approved as part of the medical necessity review. *Any days/units/visits denied as part of the medical necessity review can be appealed as outlined in the fax notification.*

NOTE: Providers should not submit a new claim for the approved days/units/visits – this will duplicate the claim and delay processing.

MODIFIERS

59	<p>Distinct Procedural Service. Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different size or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service performed on the same date, see modifier 25.</p>
76	<p>Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional. It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service.</p> <p>Note: This modifier should not be appended to an E/M service. To report a separate and distinct E/M service performed on the same date, see modifier 25. It is also inappropriate to use modifier 76 to indicate repeat laboratory services. Modifiers 59 or 91 should be used to indicate repeat or distinct laboratory services, as appropriate according to the AMA and CMS. Separate consideration for reimbursement will not be given to laboratory codes reported with modifier 76.</p>
91	<p>Repeat Clinical Diagnostic Laboratory Test. In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when</p>

	a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.
XE	Separate Encounter. A Service That Is Distinct Because It Occurred During A Separate Encounter
XS	Separate Structure. A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
XU	Unusual Non-Overlapping Service. The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

Anatomic Modifiers

<i>Modifier</i>	<i>Modifier Description</i>	<i>Modifier</i>	<i>Modifier Description</i>
E1	Upper left, eyelid	E2	Lower left, eyelid
E3	Upper right, eyelid	E4	Lower right, eyelid
F1	Left hand, second digit	F5	Right hand, thumb
F2	Left hand, third digit	F6	Right hand, second digit
F3	Left hand, fourth digit	F7	Right hand, third digit
F4	Left hand, fifth digit	F8	Right hand, fourth digit
FA	Left hand, thumb	F9	Right hand, fifth digit
T1	Left foot, second digit	T5	Right foot, great toe
T2	Left foot, third digit	T6	Right foot, second digit
T3	Left foot, fourth digit	T7	Right foot, third digit
T4	Left foot, fifth digit	T8	Right foot, fourth digit
TA	Left foot, great toe	T9	Right foot, fifth digit
LC	Left circumflex coronary artery	RC	Right coronary artery
LD	Left anterior descending coronary artery	RI	Ramus intermedius coronary artery
LM	Left main coronary artery	RT	Right side
LT	Left side		

STATE SPECIFIC INFORMATION

Vaccines for Children (VFC) statute does not permit payment for each additional vaccine/toxoid component administered in a multi-component vaccine. This disallows payment for CPT code 90461 by Medicaid, meaning physicians participating in the VFC program can only bill for CPT code 90460 when administering a multi-component vaccine.¹

The two CPT codes under the vaccine administration fees under the Vaccines for Children (VFC) program are:

- **90460** – Immunization administration through 18 years of age via any route of administration of the first vaccine/toxoid component, with counseling by physician or other qualified health care professional;
- **90461** – For each additional vaccine/toxoid component.

Note: CPT 90460 and 90461 replace 90465, 90466, 90467, and 90468.

Every vaccine administered has only one first component, and many vaccines have second and subsequent components (e.g., MMR, DTaP, and DTaP/IPV).

Providers are encouraged to use CPT 90460 for the administration of a vaccine under the VFC program. If code 90461 is used for a vaccine with multiple antigens or components, it should be given a \$0 value for a child covered under the VFC program. This applies to both Medicaid-enrolled VFC-entitled children as well as non-Medicaid-enrolled VFC-entitled children (i.e., uninsured, underinsured, and American Indian or Alaska Native children not enrolled in Medicaid).

In the VFC program, the regional vaccine administration fee cap rates were established on a per-vaccine basis, not a per-antigen or per-component basis. Under current interpretation of CMS policy, the administration fee for the VFC program will continue to be based on a per-vaccine basis and not on a per-antigen or per-component basis. States can choose to establish different rates, up to their regional caps, for vaccines with multiple antigens and for those that have only a single component. VFC-enrolled providers may not charge a vaccine administration fee to VFC-entitled children that exceed the regional administration fee cap per dose of vaccine. ²

For additional information on VFC, visit the CDC website [here](#).³ Medicaid VFC websites are noted below:

[Arizona](#)
[Florida](#)
[Georgia](#)

[Hawaii](#)
[Illinois](#)
[Kentucky](#)

[Missouri](#)
[Nebraska](#)
[New Jersey](#)

[New York](#)
[South Carolina](#)

MARKET SPECIFIC CRITERIA

Florida	Florida has an exception from CMS for CPT codes 92507 & 92508. Florida reimburses speech therapy in 15 minute time increments and allows a maximum of 4 units for each code. Florida uses a customized, state identified Maximum Frequency Per Day list
Kentucky	If code 90461 is used for a vaccine with multiple antigens or components, it should be given a \$0 value for a child covered under the VFC program.
Mississippi	MS Can has exceptions for codes 96101, 96110, 96118, 96372, H0031, H0032, H0036, H0038, H0039, H2011, H2012, H2017, H2021, H2030, T1002, T1017
Texas	<ul style="list-style-type: none"> • Multiple units allowed for codes 90460, 90461, 90472 & 90474 • Texas providers are required to bill additional vaccine administration codes on separate lines with only one unit. • Multiple units allowed for code 92507 when billed on a facility claim form. • For code A4253 Texas allows 2 units per month for insulin dependent diabetics and 1 unit per month for noninsulin dependent diabetics. • For codes A4253 and A9275 Texas allows 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. • Texas does not apply MFD to providers in POS 12 • S5101 and S5151 exempt from MFD/MUE. • H0020 exempt from MFD

CODES FOR BEHAVIORAL HEALTH OUTPATIENT TREATMENT

Covered CPT Codes

- 90832** Psychotherapy, 30 mins with patient
- 90834** Psychotherapy, 45 mins with patient
- 90837** Psychotherapy, 60 mins with patient
- 90839** Psychotherapy for crisis, first 60 min.
- 90846** Family Psychotherapy, without patient present 50 minutes
- 90847** Family Psychotherapy, 45 min (conjoint psychotherapy) (with patient present), 50 minutes
- 90849** Multiple-family group psychotherapy
- 90853** Group psychotherapy
- 90887** Interpretation explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
- 96101** Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
- 96102** Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report
- 96103** Developmental testing (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report
- 96111** Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time
- 96116** per hour of the psychologist's or physician's time, both face-to-face time with the patient and time

- interpreting test results and preparing the report
Neuropsychological Testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
- 96118** Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
- 96119** Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report
- 96120** Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
- 96125**

Covered HCPCS Codes

- G0396** Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes
- G0397** Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes
- H0006** Alcohol and/or drug services; case management
- H0010** Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient)
- H0020** Alcohol and/or drug services; methadone administration and/or service (provisions of the drug by a licensed program)
- H0036** Community psychiatric supportive treatment, face to face per 15 minutes
- H2000** Comprehensive multidisciplinary evaluation
- H2001** Rehabilitation program 1/2 day
- H2011** Crisis Intervention Services; per 15 Minutes
- H2014** Skills training and development; per 15 minutes
- H2015** Comprehensive community support services; per 15 minutes
- H2016** Comprehensive community support services; per diem
- H2017** Psychosocial rehabilitation services; per 15 minutes
- H2019** Therapeutic behavioral services; per 15 minutes
- H2020** Therapeutic behavioral services; per diem In NE Therapeutic group home
- H2021** Community-based wrap-around services; per 15 min
- H2028** Sexual offender treatment service, per 15 minutes
- H2030** Mental health Clubhouse services ; per 15 min
- H2031** Mental health Clubhouse services; per diem
- H2034** Alcohol and/or drug abuse halfway house services; per diem
- H2035** Alcohol and/or drug treatment program; per hour
- H2036** Alcohol and/or other drug treatment program; per diem
- S9484** Crisis intervention mental health services; per hour
- S9485** Crisis intervention mental health services; per diem
- T1006** Alcohol and/or substance abuse services, family/couple counseling
- T1007** Alcohol and/or substance abuse services, treatment plan development and/or modification

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

PROVIDER GUIDANCE

Q: Why do you exclude network home health services and supplies/home health agencies, anesthesia management, and ambulance providers from this policy?

A: There are many contracts specific to these physicians and other 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 unworkable. These providers were excluded until contract language and/or billing practices can be reviewed and changed.

Q: When the frequency of a billed service on a date of service is greater than the established MFD value, will there be additional reimbursement?

A: When a physician or other 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. WellCare 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 WellCare reimbursement policies such as "Laboratory Rebundling" or "Professional/Technical Component."

Q: Why is the MFD value set at 1 for bilateral procedures?

A: WellCare 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.

Q: Would the MFD value for bilateral procedures remain at 1 unit if it is possible to perform these procedures more than once per day?

A: 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.

Q: 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?

A: 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.

Q: Will WellCare allow more than 1 unit for a CPT or HCPCS code with "per diem" or "per day" in the code description?

A: WellCare 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. 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 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.

- 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
- 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

Q: What is an example of a code that is limited because of anatomical or clinical reasons?

A: CPT code 44950 (appendectomy) would be set at the MFD value of 1 unit because a person only has one appendix.

Q: How should 90460 and/or 90461 be reported when multiple immunizations with face-to-face counseling are performed on the same date of service? For example, if the physician or other health care professional 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 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-9-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-9-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.

Q: How are MFD values for immunization administration CPT codes 90472 and 90474 determined?

A: WellCare 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.

Q: What is an example of a CPT or HCPCS codes where the "description/verbiage" clearly indicates the number of units that can be performed on a single date of service?

A: Two examples are CPT Codes 11100 and 80301. Code 11100-Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion. Because the code description includes "single lesion", it should only be billed with one (1) unit. Code 80301 - Drug screen, any number of drug classes from Drug Class List A; single drug class method, by instrumented test systems (e.g., discrete multichannel chemistry analyzers utilizing immunoassay or enzyme assay), per date of service. The code description includes "per date of service", therefore it should only be billed with one (1) unit per date of service.

Q: Why are unlisted CPT and HCPCS codes set at an MFD value of 999?

A: Unlisted CPT and HCPCS codes are set at an MFD value of 999 because unlisted codes are individually reviewed; review of documentation will identify the accurate number of services performed for the unlisted code.

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.

Q: What is an example of determining the MFD value at the 100th percentile unless the 100th percentile exceeds the 98th percentile by greater than a factor of 4?

A: Statistical calculation: (A) x 4 = (C); if (B) is greater than (C), then the 98th percentile is set for the MFD value. If (B) is less than or equal to (C), then the 100th 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 th	(B) Units @ 100 th	(C) Factor of 4	Set MFD at:
86902	14	27	56	27
E0676	2	30	8	2

Q: What is an example of a clinical circumstance where WellCare would assign a specific MFD value?

A: A4595-Electrical stimulator supplies, 2 lead, per month, (e.g. TENS, NMES). According to standard criteria, the data showed the 98th percentile at 10 units and the 100th 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 WellCare Plan.

REFERENCES

1. FAQs on the Medicaid Payment Increase for Primary Care and Immunization Administration Services & Updates to the Vaccines for Children Program Regional Maximum Charges. American Academy of Pediatrics Web site. https://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/documents/faquidmedicaidpaymentrule_dec2012.pdf. Accessed January 16, 2018.
2. VFC: Frequently Asked Questions. State of Kentucky Department for Health and Human Services Web site. Available [here](#). Accessed January 16, 2018.
3. Vaccines for Children (VFC) Program. Centers for Disease Control and Prevention Web site. <https://www.cdc.gov/vaccines/programs/vfc/index.html>. Published February 18, 2016. Accessed November 28, 2017.
4. American Medical Association, Current Procedural Terminology (CPT®) Professional Edition and associated publications and services.
5. Publications from the Centers for Medicare and Medicaid Services including the CMS Manual System.
6. Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets.

LEGAL DISCLAIMER

The Claims Edit Guideline (CEG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this CEG. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the CEG. Additionally, CEGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CEG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

Easy Choice Health Plan ~ Harmony Health Plan of Illinois ~ Missouri Care ~ Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona
OneCare (Care1st Health Plan Arizona, Inc.) ~ Staywell of Florida ~ WellCare Prescription Insurance ~ WellCare Texan Plus (Medicare – Dallas and Houston markets)
WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	Action
4/27/2018	<ul style="list-style-type: none"> • Approved by MPC. Inclusion of items for behavioral health outpatient treatment.
2/1/2018	<ul style="list-style-type: none"> • Approved by MPC. Included statement on Vaccines for Children (VFC) – see <i>State Specific Information</i> section. Also included information from CDC re: 90460 and 90461 – see <i>Position Statement</i> section.
10/10/2017	<ul style="list-style-type: none"> • Approved by MPC. No changes; updated for compliance only while finalizing edits for future date.
9/17/2015	<ul style="list-style-type: none"> • Approved by MPC. New.