

Putting it into Perspective – Medically Unlikely Edits

Medicare has implemented a claims review process called Medically Unlikely Edits or MUEs. This article answers some frequently asked questions on MUEs and provides some suggestions on how to proceed with getting appropriate claims paid by Medicare.

What are MUEs?

Starting January 2007, Medically Unlikely Edits were implemented to place limits on the frequency that individual codes could be billed. These edits are generally based on anatomical considerations. For example, a surgeon generally can take out only one appendix from an individual on one day. CMS could create an edit for CPT®44950 – Appendectomy that would set a limit of one procedure per day per patient. Claims with a frequency greater than one for CPT® 44950 would not pay.

MUE edits are applicable only to a single provider to a single beneficiary on the same date of service. The goal of MUE edits is to reduce claims payment errors due to clerical entry mistakes or incorrect coding. Only a limited number of CPT codes have an associated MUE. The actual MUE limits currently used by CMS will be publically available starting October 2008. However due to fraud concerns, CMS will not release the MUE limits for codes where the limit is 4 or more. This means that several radiation oncology MUE limits will not be released. Please note that, prior to implementation, AMA participating specialty societies, including ACRO, have the opportunity to comment on the proposed edits regardless of the proposed number. Through the Economics Committee, ACRO regularly reviews the proposed edits and provides comment.

Since MUEs are relatively new, CMS has a detailed FAQ section on the CMS web site, which can be accessed at: http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage. Additionally, ACRO's most recent article on the medically unlikely edit for CPT®77300 – basic dosimetry calculation per day is available through our web site under (insert location for 12/12/07 article).

How do MUEs differ from CCI edits?

CCI edits have been used since 1996 and exam claims for particular code pairings (2 codes billed for the same date of service). MUEs are different since an MUE looks at a single code and limit the number of times on a date of service that a particular code can be billed. CCI edits can deny one code outright as being a component of the primary code (mutually exclusive denial). Other times a code is denied because it is generally not appropriate to bill that code pairing together (column 1/column2 edit). In this situation, an appropriate modifier will allow the claim to pay. Unlike MUEs, all NCCI edits are publically available at the CMS web site www.cms.hhs.gov/NationalCorrectCodInitEd/.

If a claim exceeds an MUE, how can I get paid?

MUEs test entire claims lines against a specified number of units. If a single claim line exceeds the MUE limit, one of two things generally can happen.

1. For those claims processed by fiscal intermediaries and Part A/Part B Medicare Administrative Contractors **on the Fiscal Intermediary Shared System (FISS)**, the claim is returned to the provider where the claim lines have units of services exceeding the MUE limit. The claim line is not denied, so no appeal process exists. Instead, providers should resubmit corrected claims.
2. When a claim is processed by a fiscal Intermediary or a Part A/Part B Medicare Administrative Contractor **on the Medicare Claims System (MCS)**, the fiscal intermediary will deny the entire claim line if the units of service on the line exceed the MUE limit. Since claim lines are denied, the denial may be appealed. In the rare situation where a claim is processed on the **Viable Information Processing System (VMS)** (usually for durable medical equipment claims), the entire claim line is denied when the MUE limit is exceeded. Since claim lines are denied, the denial may be appealed.

I am having problems with complex head/neck cases denying CPT® 77300 – basic dosimetry calculation per day. What do I do?

If billing for multiple dates of service was included in one claim line, determine whether to bill each date of service on its own claim line. Some fiscal intermediaries allow for multiple units of service to be reported on a single claim line for repetitive services performed over a date range. If you report services in this manner, report the “from date” and the “to date” on the claim line. Fiscal intermediaries should divide the units of service by the number of days in the date span and round to the nearest whole number. This calculated number is then compared to the MUE for the code on the claim line.

Sometimes there are situations where it is medically reasonable and necessary to exceed the MUE limitation on a single date of service. In such situations, use CPT modifiers to report the same code on separate lines of a claim. CPT modifiers such as -76 (repeat procedure by same physician), -77 (repeat procedure by another physician, this would rarely if ever occur in Rad Onc and could be viewed as manipulation for payment), anatomic modifiers (e.g., RT, LT, F1, F2), and -59 (distinct procedural service) will accomplish this purpose. Modifier -59 should be utilized only if no other modifier describes the service. As always, documentation of clinical activities supporting the appropriate use of the modifiers should be maintained in the medical record.

Resources used to prepare this document:

- MedLearns Matters (MLN MM5402), released 12/8/06
- Questions posted on line: 8735 updated 11/7/07; 8736 updated 11/7/07; 8737 updated 11/7/07; and 8738 updated 11/7/07

- Medicare Claim Review Programs; MR, NCCI Edits, MUEs, CERT & RAC available on CMS web site.
- Letter from CMS to AMA and Specialty Societies, dated September 18, 2008 re public release of MUE limits.

Some of my claims were denied for due to MUE edits. Can I bill the patient?

An MUE denial, just like a CCI edit denial, is not a medical necessity denial. It is a coding denial. Even if you have an Advanced Beneficiary Notice (ABN)¹ on file, claims denied based on the MUE edits cannot be billed to the patient. In an April 14, 2009 letter, CMS states that providers cannot utilize an ABN “under any circumstances” to bill a Medicare patients for a service denied due to an MUE “even if the denial is upheld due to lack of medical necessity on appeal.” You are prohibited from billing the patient for services denied due to an MUE edit.

¹ Medicare allows an Advance Beneficiary Notice of Noncoverage (ABN) to be given to a Medicare beneficiary whenever the treating clinician determines that the services being provided are no longer expected to be covered because they do not satisfy Medicare’s medical necessity requirements. Where an ABN is validly given (for medical necessity denials, NOT coding denials), the provider can then bill for services that Medicare may deny due to the lack of medical necessity.