Medicare Denials of Claims because of “Edits”

This article discusses the denial of Medicare claims through two Medicare programs: Medically Unlikely Edits (MUE) and Recovery Audit Contractor (RAC) programs. MUEs are a maximum number of units that a provider would likely report under most circumstances for a single beneficiary on a single date of service. For example, MUEs deny reimbursement if a provider bills for removing more than one complete gallbladder on a single patient on a single day. CMS has published MUE limits for approximately 69 codes that pertain to Radiation Oncology;¹ while other MUE values remain confidential and are not released or published.

In radiation oncology, there may be rare situations where it is medically reasonable and necessary to exceed the MUE limit on a single date of service. As always, documentation of clinical activities supporting the appropriate use of the modifiers should be maintained in the medical record. In this newsletter we will utilize CPT 77300 (basic dosimetry calculation) as a sample code since: (1) In February 2011 at least one CMS contractor² has published they will require supporting documentation when more than 10 units of 77300 are charged; and (2) In September 2010 at least one Medicare Recovery Audit Contractors (RAC)³ has identified 77300 as a potential code being looked at. Overutilization or reporting errors may have contributed to this review.

Claims in excess of existing MUEs may be denied and the provider will get zero reimbursement. In that case, the provider has the option of: (1) resubmitting the claim with a “corrected” number of units (if there was an error); (2) resubmitting the claim with the same number of units, if valid/correct, with an appropriate modifier; or (3) begin the appeals process for payment.

For 77300, one local coverage determination (LCD) indicates that “this procedure need not be routinely performed each time the patient is treated. …Supporting documentation will be requested for dosimetry calculations of greater than ten (10).”⁴ The following states have a RAC review ongoing for CPT 77300: IL, IN, KY, MI, MN, OH, and WI.

Even if you successfully receive payment for a claim after an initial denial, ACRO would suggest that you ensure that there is evidence of medically necessity in the patient record. MUE values are not intended to be utilization guidelines. Rather, providers should report only services that are medically reasonable and necessary with an understanding of the MUE system. ACRO strongly suggests that when a known MUE number is exceeded, or when an unusually high number of services is billed and could trigger an MUE denial, that the provider accompany the initial billing materials with extensive documentation for the need of the service provided. This may prevent denials, and will assist in subsequent appeals if necessary and appropriate.

We recommend that ACRO members do not intentionally under-bill for clinically reasonable services that exceed published MUE values for fear of denials or the need for submitting medical

¹ http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp
³ http://racb.cgi.com/issues.aspx
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records for documentation. We also recommend that denials be reported to the physician so he/she can check the medical necessity of needing these multiple units. We strongly recommend against over-billing the number of services provided even if it remains under published MUEs limit. Over-billing is considered fraud and places your practice in a high-risk environment.

SUMMARY

Providers should always bill for the number of units provided that are clinically reasonable and medically necessary. In the event that a provider exceeds the MUE values for a given code and is denied reimbursement, the provider should bill the correct number of units performed and be prepared to appeal the claim denial with: 1) documentation of medical necessity and, 2) a physician signature (or physician supervision signature). Claims for medically appropriate services that exceed MUE values should be properly processed to include applicable modifiers.

Do not over- or under- bill; documentation of medical necessity (even if you receive reimbursement) is important to avoid RAC audits. Please let ACRO know if you see a persistent problem.

Other suggestions for providers include:

- Developing an understanding of the current and proposed CMS guidance and the generally accepted units of service for procedures. Providers can discuss these limits with their FI or MAC, if necessary;
- Creating an internal system within your organization to review claims for possible errors, and to be aware of the MUEs prior to submitting the claim; and
- Monitoring quarterly changes to the published MUE list. The list of published MUEs is available on the CMS website: http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp. Read about RAC audits pertaining to radiation oncology codes.
- Get involved with the ACRO Economics Committee. Interested members should email Audrey at Audrey.el-gamil@dobsondavanzo.com but be aware that you will have to attend monthly meetings and help out with projects relating to radiation oncology.