

Timely Topics

PAYMENT AND PRACTICE MANAGEMENT

April 2015

Modifications to Medicare's MUE Program

The Centers for Medicare and Medicaid Services (CMS) have long been looking for ways to save the Medicare program money and to reduce paid claim error rates. CMS implemented the National Correct Coding Initiative (NCCI) procedure-to-procedure claims edits in 1996. In 2007, CMS added another type of claims edit under NCCI – Medically Unlikely Edits (MUE) which is a screen that established a limit on the number of times a specific may be reported on the same date of service. Initially, the MUE value was adjudicated against the units of service (UOS) reported on each line of a claim instead of against the entire claim. In April of 2013, CMS modified the MUE program so that some MUE values would be date of service edits rather than just claim line edits. At that time, CMS introduced a new data field to the MUE table called the “MUE Adjudication Indicator (MAI)”. CMS published a MedLearn Matters® article [SE1422](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1422.pdf) titled *Medically Unlikely Edits (MUE) and Bilateral Procedures* that not only discussed how to report bilateral procedures, but referenced additional modifications made to the MUE Program which makes the edits more understandable. <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1422.pdf>

If you are not familiar with MUE edits or need a refresher on what an MUE is, this type of coding edit limits the Units of Service (UOS) allowable under most circumstances for a single Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a date of service for a single beneficiary. MUEs apply not only to services and procedures but also to durable medical equipment and drugs. MUEs are based on many different factors such as anatomic considerations, HCPCS/CPT code descriptors, CPT coding instructions, CMS policies (national and local policies), coding guidelines developed by national societies, analysis of standard medical and surgical practices, a review of current coding practices, and prescribing information.

Many MUE edits are being converted into per day edits following a review of CMS' claims data relative to MUE levels, where a pattern of inappropriate billing using multiple lines to bypass the MUEs was confirmed. This analysis resulted in the establishment of a MUE Adjudication Indicator (MAI) which specifies the type of MUE and the basis for the MUE. A MUE Adjudication Indicator is either a 1 (line edit), 2 (absolute date of service edit), or 3 (date of service edit). The Practitioner Services MUE table which is published quarterly now includes the rationale behind a MUE. The Practitioner Services MUE Values column, which is not new to the MUE table, indicates how many UOS can be reported by a provider on a date of service for a single beneficiary.

Timely Topics

PAYMENT AND PRACTICE MANAGEMENT

Below is an example of the revised Practitioner Services MUE table:

HCPCS/CPT Code	Descriptor	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	2	1 Line Edit	Clinical Data
95972	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, up to 1 hour	1	2 Date of Service Edit: Policy	Code Descriptor/CPT Instructions
64484	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	4	3 Date of Service Edit: Clinical	Clinical: Data

Timely Topics

PAYMENT AND PRACTICE MANAGEMENT

The three MAIs noted previously, are defined as follows:

“1” indicates a line edit. Medically appropriate units of service in excess of the MUE may be reported on a separate line with an appropriate modifier and each line will be processed for payment.

- An example of a MAI of “1” is billing code 36556 with more than 2 UOS since it would only be on occasion that more than two separate access sites to the central circulation system is required.

“2” is an absolute date of service edit. This type of edit is based on regulation or subregulatory instructions, including the instruction that is inherent in the code descriptor or its applicable anatomy. MAI of “2” edits are rigorously reviewed and vetted by CMS and receive this MAI designation because UOS on the same date of service (DOS) in excess of the MUE value, would be considered impossible because it is contrary to statute, regulation, or subregulation guidance. This subregulatory guidance includes clear correct coding policy which is binding on both providers and the Medicare Administrative Contractors (MACs). CMS believes that claims reporting services in excess of the MUE for edits with an MAI of 2 represent either a clerical error or a misinterpretation of instructions. Since CMS has not identified any instances in which higher value would be correct and payable, MACs have been instructed that this subregulatory instruction is binding on the MAC for both initial and redeterminations.

- An example of a MAI of “2” is billing code 95972 with 2 UOS where the descriptor states “up to one hour”. If the procedure takes an hour and half, 95972 would be billed with 1 UOS on one claim line and +95973 (*Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure))*) with 1 UOS on the second claim line.

“3” indicates a date of service edit and is the most common per day edit. An MAI of “3” indicates an edit for which the MUE is based on clinical information such as billing patterns, prescribing instructions, or other information. Exceptions to the MUE are rare, but MACs may pay in excess of the MUE value if there is adequate documentation of medical necessity of correctly reported units. If MACs have pre-payment evidence (e.g. medical review) that the UOS in excess of the MUE value were actually provided, were correctly coded, and were medically necessary, the MACs may bypass the MUE during claims processing, reopening,

Timely Topics

PAYMENT AND PRACTICE MANAGEMENT

or redetermination, or in response to instructions from a reconsideration or higher level appeal.

Providers should carefully assess denials based on these edits and consider whether the denial may be indicative of incorrect reporting due to a clerical error or an error in interpretation of coding instructions. It is also possible that the error could be associated with lack of medical necessity for the excess units, although MUEs do not address medical necessity.

- An example of a MAI of “3” is code +64484 which has a MUE value of 4. This value takes into consideration the number of levels of the lumbar spine that can be injected, which is 5 (an anatomic consideration). Code 64483 represents the first level of the lumbar spine to be injected. Additional levels would be reported with code +64484. *64484 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)*

For all MUE edit denials, and as an alternative to filing an appeal, if the provider identifies a clerical error and the correct value is equal to or less than the MUE, the provider may request a reopening of the claim denial to correct the claim. But CMS cautions against routinely using this method to correct unintentional errors and that reopening requests do not extend the window for filing appeals. If the appeals process is used, appeals are to be submitted to your MAC not the NCCI/MUE contractor.

Although CMS publishes most MUE values on its website, some MUE values are not disclosed and are for CMS and CMS Contractors' use only. MUEs that are published are posted on the CMS website on a quarterly basis. Like all NCCI edits, the MUE file is updated quarterly and may be accessed from

<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd/>