COMPLIANCE TIP

TO: Compliance Alert Distribution List

FROM: Maryann C. Palmeter, CPC, CENTC, CPCO, CHC, AAPC Fellow, Director, Office of Physician Billing Compliance

SUBJECT: Understanding Medically Unlikely Edits

DATE: July 24, 2018

On occasion, the Office of Compliance receives assistance requests when a "MUE" results in a service denial. "MUE" is an acronym for "Medically Unlikely Edits." The Centers for Medicare and Medicaid Services (CMS) developed the MUE program to reduce the Medicare Part B paid claims error rate. Edits are based on anatomic considerations, procedure code descriptors, CPT® instructions, CMS policies, the nature of a service or procedure, the nature of an analyte, the nature of equipment, CMS data, and clinical judgment. These edits are set to deny claim lines exceeding the acceptable maximum number of units on the same service date for the same patient. This tip is quite lengthy but it provides a detailed explanation of these edits along with several illustrations of edit rationale.

CMS updates MUE files at least quarterly. Here is a link to the MUE page on CMS’ website:

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

There are three tables or sets of edits: DME, Facility, and Practitioner. It is important to access the relevant set as the edits vary from table to table. Physicians and qualified healthcare practitioners would utilize the Practitioner table. Some MUE remain confidential out of concern for potential abuse and are not published.

The MUE Table lists the HCPCS/CPT® code, the MUE value, the MUE Adjudication Indicator ("MAI"), and the MUE rationale.

The MUE Values column lists the maximum number of units per claim line or date of service. If the MUE value is listed as "0," the HCPCS/CPT® code is invalid, not covered, bundled, not separately payable, statutorily excluded, or not reasonable and necessary in accordance with Medicare regulations or guidance. This is one area where private payers may have different rules as they may cover some of the services that Medicare does not.
Each MUE has a “MUE Adjudication Indicator” (MAI) which categorizes the MUE as a one-line edit or a date of service edit.

The MUE tables also include an “Edit Rationale” for each HCPCS/CPT® code. Although a MUE may be based on several rationales, only one is displayed in the edit table. One of the listed rationales is “Data.” This rationale indicates that 100% Medicare Part B claims data from a six-month period was the major factor in determining the MUE value.

One-Line Edit MAI
These edits will be applied on a detail line basis. The units of service on each claim line are compared to the MUE value for the HCPCS/CPT® code on that claim line. If the units exceed the MUE value, all units on that claim line are denied.

*Table 1* illustrates a line edit for CPT® code 47539 (Placement of stent(s) into bile duct...new access, without placement of separate biliary drainage catheter). The MUE Value is set at “2.” The introduction within the Biliary Tract subsection of CPT® specifies that CPT® code 47539 may be reported more than once in the same session using Modifier 59 for the additional procedures in the following circumstances: 1) placement of side-by-side (double-barrel) stents within a single bile duct; 2) placement of two or more stents into separate bile ducts through a single percutaneous access; or 3) placement of stent(s) through two or more percutaneous access sites.

<table>
<thead>
<tr>
<th>HCPSC/ CPT® Code</th>
<th>Practitioner Services MUE Values</th>
<th>MUE Adjudication Indicator</th>
<th>MUE Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>47539</td>
<td>2</td>
<td>1 Line Edit</td>
<td>Nature of Service/Procedure</td>
</tr>
</tbody>
</table>

Date of Service MAI
If the MUE is adjudicated as a date of service edit, all units on each claim line for the same date of service for the same HCPCS/CPT® code are summed, and the sum is compared to the MUE value. If the summed units on the claim exceed the MUE value, all units for the HCPCS/CPT® code for that date of service are denied. Date of service edits are utilized for HCPCS/CPT® codes where it would be extremely unlikely that more units than the MUE value would ever be performed on the same date of service for the same patient.

Edits for HCPCS/CPT® codes with a MAI of “2” are absolute date of service edits. These are per day edits based on policy. Units of service on the same date of service in excess of the MUE value would be considered impossible as billing in this fashion would be contrary to Medicare statute, regulations, or guidance. For example, it would be contrary to correct coding policy to report more than one unit of service for CPT 94002 (ventilation assist and management . . . initial day) because there can only be one “initial day” for the same patient.

*Table 2* illustrates the MUE values for procedure codes 17000, 17003, and 17004. It would be inappropriate to report CPT® code 17000 with units greater than “1” on the same
service date for the same patient. The CPT® code definition stipulates that this code be reported for the 1st premalignant lesion only. As such, any additional premalignant lesions should be reported with a different CPT® code. Likewise, it would be inappropriate to report CPT® code 17003 with units greater than 13 as the code description stipulates that this code be reported for the 2nd through the 14th premalignant lesion. Units may be adjusted up to 13. Any additional premalignant lesions should be reported with CPT® code 17004. Lastly, it would be inappropriate to report CPT® code 17004 with units greater than one (1) because the code description stipulates 15 or more lesions. In essence, this code should be reported once for any premalignant lesions greater than 14 that are destroyed on the same service date for the same patient. Because CPT® codes 17000, 17003, and 17004 do not stipulate an anatomical location, it would be inappropriate to report Modifier 59 (distinct, procedural service) with any of these CPT codes.

**Table 2**

<table>
<thead>
<tr>
<th>HPCPS/ CPT® Code</th>
<th>Practitioner Services MUE Values</th>
<th>MUE Adjudication Indicator</th>
<th>MUE Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>17000</td>
<td>1</td>
<td>2 Date of Service Edit: Policy</td>
<td>Code Descriptor / CPT Instruction</td>
</tr>
<tr>
<td>17003</td>
<td>13</td>
<td>2 Date of Service Edit: Policy</td>
<td>Code Descriptor / CPT Instruction</td>
</tr>
<tr>
<td>17004</td>
<td>1</td>
<td>2 Date of Service Edit: Policy</td>
<td>Code Descriptor / CPT Instruction</td>
</tr>
</tbody>
</table>

**Table 3** illustrates a MAI 2 edit based on CMS policy for CPT code 15822 (blepharoplasty, upper eyelid). Per CMS policy, it would be inappropriate to report more than one unit of CPT code 15822 (blepharoplasty, upper eyelid) on the same date for the same patient without a modifier as the maximum units for this code is one (1). When this service is performed bilaterally, report on a single claim line and append Modifier 50 (bilateral procedure) to the CPT® code. Report units as one (1). If performed unilaterally, append either the "RT" (right side) or "E3" (upper right, eyelid) modifier when performed on the right side of the body or the "LT" (left side) or "E1" (upper left, eyelid) modifier when performed on the left side of the body. Report units as one (1) for this scenario as well. Because the bilateral surgery indicator for this CPT® code is one (1), payment is based on either the lower of the sum of the actual charges for both procedures or 150% of the Medicare fee schedule amount for a single code. CMS policy for reporting bilateral surgical procedures is to report the procedure code on a single claim line with modifier 50 and one (1) unit of service. When Modifier 50 is required by manual or coding instructions, claims submitted with two lines or two units and anatomic modifiers will be denied for incorrect coding. Again, private payer policy may vary from Medicare’s policy.

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Edits for HCPCS/CPT® codes with a MAI of “3” are date of service edits. These are per day edits based on clinical benchmarks. The rationale may be CMS policy, anatomic considerations, or data driven. If claim denials based on these edits are appealed, Medicare Administrative Contractors (MACs) may pay units of service in excess of the MUE value if there is adequate documentation of medical necessity for correctly reported units.

Table 4 illustrates a MUE Value of “1” for CPT® code 96003 (Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle). The edit is based on the nature of the service. Specifically, CPT® code 96003 is for one (1) muscle; therefore, the units of service should not exceed one (1).

Some MUE are date of service edits based on clinical information. Table 5 illustrates a MUE where the edit rationale is based on prescribing information. The maximum units of service are based on dosage for the patient type (i.e., adult vs. child). In this example, HCPCS Level II code J0500 is for DICYCLOMINE HCL or BENTYL, up to 20 mg. The prescribing information lists the recommended intramuscular dose in adults as 10 mg. to 20 mg. four times a day. The maximum units of service per day per the prescribing information would be 4. Doses in excess of this fall outside of the suggested dosage for adults.

<table>
<thead>
<tr>
<th>HCPCS/ CPT® Code</th>
<th>Practitioner Services MUE Values</th>
<th>MUE Adjudication Indicator</th>
<th>MUE Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>15822</td>
<td>1</td>
<td>2 Date of Service Edit: Policy</td>
<td>CMS Policy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPCS/ CPT® Code</th>
<th>Practitioner Services MUE Values</th>
<th>MUE Adjudication Indicator</th>
<th>MUE Rationale</th>
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</thead>
<tbody>
<tr>
<td>96003</td>
<td>1</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Nature of Service/Procedure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPCS/ CPT® Code</th>
<th>Practitioner Services MUE Values</th>
<th>MUE Adjudication Indicator</th>
<th>MUE Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0500</td>
<td>4</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Prescribing Information</td>
</tr>
</tbody>
</table>
Modifier Usage
The appropriate use of CPT® modifiers (e.g., 25, 50, 76, 77, 91, 59) or HCPCS Level II modifiers (e.g., E1, E4, F2, FA, LC, LT, RT) to report the same code on separate lines of a claim will enable a provider or supplier to report medically reasonable and necessary units of service in excess of a MUE value.

Denials
A denial of services due to a MUE is a coding denial, not a medical necessity denial. The presence of an Advance Beneficiary Notice (ABN) will not shift financial liability to the patient for units of service denied based on a MUE.

MUE are not utilization edits. Although the MUE value for some codes may represent the commonly reported units of service (e.g., MUE of “1” for appendectomy), the usual units of service for many HCPCS/CPT® codes is less than the MUE value. Providers should continue to report only services that are medically reasonable and necessary.

Claims processing contractors may have units of service edits that are more restrictive than MUE. In such cases, the more restrictive claims processing contractor edit would be applied to the claim. Similarly, if the MUE is more restrictive than a claims processing contractor edit, the more restrictive MUE would apply.

If a provider encounters a code with frequent denials due to a MUE or a modifier submitted to bypass a MUE, the provider or supplier should ensure the following:

- the HCPCS/CPT® code reported was correct;
- the units of service were counted correctly (e.g., per joint vs. per nerve);
- an applicable and appropriately documented modifier was submitted; and
- the number of services reported were medically reasonable and necessary.

If the claim was submitted correctly, then perhaps it is time to question why the provider’s practice differs from national patterns. Providers do have the opportunity to request updates to the MUE edits but they need to be prepared to submit supporting clinical and/or specialty society documentation with their request.

- Address inquiries about a specific claim to the local Medicare Administrative Contractor (MAC).
- Address inquiries about the rationale for a MUE value to the local MAC or a national healthcare organization whose members often perform the procedure.
- Providers or other parties still wanting to submit a request for reconsideration of a MUE value should send their request along with proposed MUE value and supporting documentation to:

Patient Care • Research • Education

UF Health is a collaboration of the University of Florida Health Science Center. Shands hospitals and other health care entities.
National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907
Carmel, IN 46082-0907

Fax #: 317-571-1745

Medicaid and Private Payers
Medicaid adheres to CMS' National Correct Coding Initiative (NCCI) and part of that initiative is the Medically Unlikely Edits. Private payers often adopt CMS' NCCI edit logic into their claims systems. It is best that you review your contracts and commercial payer policies for guidance and be sure to watch your remittance vouchers (i.e., Explanation of Benefits) very closely.

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