



Manual:	Reimbursement Policy		
Policy Title:	Medically Unlikely Edits (MUEs)		
Section:	Administrative		
Subsection:	None		
Date of Origin:	5/14/2012	Policy Number:	RPM056
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Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

Reimbursement Guidelines

- A. Moda Health applies and follows the CMS published Medically Unlikely Edits (MUE) unit limitations.
 - 1. CMS publishes two sets of MUE files, which are publically available on the CMS website to all provider offices:
 - a. Professional, which apply to professional and Ambulatory Surgery Center (ASC) claims.
 - b. OPPOS MUE's, which apply to outpatient claims submitted on CMS1450 claim forms.
 - 2. Special limit quantities for a few procedure codes.
 - a. For Commercial lines of business only, Moda Health uses MUE quantities that are more generous than the CMS-defined MUE limits for a select few codes.
 - b. These limits have been established by review and involvement of Healthcare Services, a medical director, and/or an external medical consultant.
 - c. These exceptions are limited to a few allergy and behavioral health procedure codes.
- B. MUE Adjudication Indicators (MAI) and their significance.
 - 1. An MUE Adjudication Indicator (MAI) of "1" indicates that the edit is a claim line MUE.
 - a. Appropriate use of NCCI modifiers (e.g., 59, 76, 77, 91, anatomic) may be used to report the same HCPCS/CPT code on separate lines of a claim.
 - b. Medical records must support the total units for the date of service and the use of the modifiers appended.

2. MUE edits with an MUE Adjudication Indicator (MAI) of “2” (Date of Service Edit: Policy):
 - a. The MUE value is an absolute date of service limit that may not be overridden or bypassed with a modifier.
 - b. MUE edit limits with an MAI of “2” have been rigorously reviewed and vetted within CMS.
 - c. Units in excess of the MUE value on a date of service would be considered impossible because of the code definition, anatomical consideration, CMS statute, regulation or subregulatory guidance. (See also C. Bilateral Procedure MUE’s.)
3. MUE edit limits with an MUE Adjudication Indicator of “3” (Date of Service Edit: Clinical):
 - a. It would be possible but medically highly unlikely that more units than the MUE value would ever be performed on the same date of service for the same patient.
 - b. CMS set these quantity limits based on clinical benchmarks and criteria (e.g., nature of service, prescribing information) combined with CMS data.
 - c. The MUE limits will be applied during claim processing.
 - d. For reconsideration review for higher quantities, a written appeal is required accompanied by medical records. The appeal and records must document units of service excess of the MUE value were:
 - i. Actually provided.
 - ii. Correctly coded.
 - iii. Medically necessary.

C. Bilateral Procedure MUEs

1. Many surgical procedures may be performed bilaterally. Procedure codes with a bilateral surgery rules indicator of “1” on the CMS Physician Fee Schedule, are to be reported using modifier 50 with one unit of service. The MUE value for many of these codes is a limit of one (1) unit.
2. “Each additional level” add-on codes that may be performed bilaterally at multiple levels (e.g. 64480, 64484) have an MUE daily limit of more than one unit. Each unit reported with modifier 50 describes the performance of bilateral services at a specific level; a maximum of one unit may be reported for each level documented in the record.

Background Information

CMS has established units of service edits referred to as Medically Unlikely Edit(s) MUEs).

An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances allowable by the same provider for the same beneficiary on the same date of service.

The ideal MUE value for a HCPCS/CPT code is the unit of service that allows the vast majority of appropriately coded claims to pass the MUE. Separate MUE values have been established for practitioner claims, outpatient facility services, and Durable Medical Equipment (DME) claims.

Codes, Terms, and Definitions

Acronyms Defined

Acronym		Definition
ASO	=	Administrative Services Only
CMS	=	Centers for Medicare and Medicaid Services
DOS	=	Date of service
E/M	=	Evaluation and management (service)
MAI	=	MUE Adjudication Indicator
MUE(s)	=	Medically Unlikely Edit(s)
UOS	=	Unit(s) of Service

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

“DOS MUEs are utilized for HCPCS/CPT codes where it would be extremely unlikely that more UOS than the MUE value would ever be performed on the same date of service for the same patient.” (CMS¹)

“MUEs for HCPCS codes with an MAI of “2” are absolute date of service edits. These are “per day edits based on policy”. HCPCS codes with an MAI of “2” have been rigorously reviewed and vetted within CMS and obtain this MAI designation because UOS on the same date of service (DOS) in excess of the MUE value would be considered impossible because it was contrary to statute, regulation or subregulatory guidance. This subregulatory guidance includes clear correct coding policy that is binding on both providers and CMS claims processing contractors. Limitations created by anatomical or coding limitations are incorporated in correct coding policy, both in the HIPAA mandated coding descriptors and CMS approved coding guidance as well as specific guidance in CMS and NCCI manuals. 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 such usage could not accurately describe two initial days of management occurring on the same date of service as would be required by the code descriptor. As a result, claims processing contractors are instructed that an MAI of “2” denotes a claims processing restriction for which override during processing, reopening, or redetermination would be contrary to CMS policy.

MUEs for HCPCS codes with an MAI of “3” are “per day edits based on clinical benchmarks”. MUEs assigned an MAI of “3” are based on criteria (e.g., nature of service, prescribing information) combined with data such that it would be possible but medically highly unlikely that higher values would represent correctly reported medically necessary services. If contractors have evidence (e.g., medical review) that UOS in excess of the MUE value were

actually provided, were correctly coded and were medically necessary, the contractor may bypass the MUE for a HCPCS code with an MAI of “3” during claim processing, reopening or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal.” (CMS¹)

“Both the MAI and MUE value for each HCPCS/CPT code are based on one or more of the following criteria:

- 1) Anatomic considerations may limit units of service based on anatomic structures. For example, the MUE value for an appendectomy is “1” since there is only one appendix.
- 2) CPT code descriptors/CPT coding instructions in the CPT Manual may limit units of service. For example, a procedure described as the “initial 30 minutes” would have an MUE value of “1” because of the use of the term “initial”.
- 3) Edits based on established CMS policies may limit units of service. For example, the bilateral surgery indicator on the Medicare Physician Fee Schedule Database (MPFSDB) may limit reporting of bilateral procedures to a single unit of service reported with a bilateral modifier.
- 4) The nature of an analyte may limit units of service and is in general determined by one of three considerations:
 - a) The nature of the specimen may limit the units of service as for a test requiring a 24-hour urine specimen.
 - b) The nature of the test may limit the units of service as for a test that requires 24 hours to perform.
 - c) c) The physiology, pathophysiology, or clinical application of the analyte is such that a maximum unit of service for a single date of service can be determined. For example, the MUE for RBC folic acid level is one since the test would only be necessary once on a single date of service.
- 5) The nature of a procedure/service may limit units of service and is in general determined by the amount of time required to perform a procedure/service (e.g., overnight sleep studies) or clinical application of a procedure/service (e.g., motion analysis tests).
- 6) The nature of equipment may limit units of service and is in general determined by the number of items of equipment that would be utilized (e.g., cochlear implant or wheelchair).
- 7) Clinical judgment considerations and determinations are based on input from numerous physicians and certified coders.
- 8) Prescribing information is based on FDA labeling as well as off-label information published in CMS approved drug compendia.

- 9) Submitted claims data (100%) from a six month period is utilized to ascertain the distribution pattern of UOS typically billed for a given HCPCS/CPT code.” (CMS¹)

“Many surgical procedures may be performed bilaterally. Instructions in the CMS Internet-only Manual (Publication 100-04 Medicare Claims Processing Manual, Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 20.6.2 require that bilateral surgical procedures be reported using modifier 50 with one unit of service. If a bilateral surgical procedure is performed at different sites bilaterally (e.g., transforaminal epidural injections (CPT codes 64480, 64484)), one unit of service may be reported for each site. That is, the HCPCS/CPT code may be reported with modifier 50 and one unit of service for each site at which it was performed bilaterally.” (CMS¹)

“Suppliers should not assume that they may report units of service up to the MUE value on each date of service. Suppliers may only report supply items that are medically reasonable and necessary.” (CMS¹)

“Most MUE values are set so that a provider or supplier would only very occasionally have a claim line denied. If a provider encounters a code with frequent denials due to the MUE or frequent use of a CPT modifier to bypass the MUE, the provider or supplier should consider the following: (1) Is the HCPCS/CPT code being used correctly? (2) Is the unit of service being counted correctly? (3) Are all reported services medically reasonable and necessary? and (4) Why does the provider’s or supplier’s practice differ from national patterns? A provider or supplier may choose to discuss these questions with the local Medicare contractor or a national healthcare organization whose members frequently perform the procedure.” (CMS¹)

“Since MUEs are coding edits rather than medical necessity edits, claims processing contractors may have units of service edits that are more restrictive than MUEs. 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.” (CMS¹)

“A provider, supplier, healthcare organization, or other interested party may request reconsideration of an MUE value for a HCPCS/CPT code. A written request proposing an alternative MUE with rationale may be sent to:

National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907
Carmel, IN 46082-0907
Fax: 317-571-1745”

(CMS¹)

Cross References

“Clinical Editing.” Moda Health Reimbursement Policy Manual, RPM002.

References & Resources

1. CMS. “Medically Unlikely Edits (MUEs).” *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § V.

IMPORTANT STATEMENT

The purpose of Moda Health Reimbursement Policy (formerly ODS Health Plan, Inc.) is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS’ National Correct Coding Initiative (CCI/NCCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.