Medically Unlikely Edits

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PRACTICE **POINTS**

- Medically Unlikely Edits (MUEs) are designed to prevent incorrect or excessive coding. Units of service billed in excess of the MUE will not be paid.
- Three different MUE adjudication indicators (MAIs) were added so that some MUE values would be date of service edits.
- Dermatologists should be vigilant for unexpected payment denials.

Medically Unlikely Edits (MUEs) are benchmarks recognized by the Centers for Medicare & Medicaid Services (CMS) that are designed to prevent incorrect or excessive coding. Specifically, an MUE is an edit that tests medical claims for services billed in excess of the maximum number of units of service permitted for a single beneficiary on the same date of service from the same provider (eg, multiples of the same Healthcare Common Procedure Coding System [HCPCS] code listed on different claim lines).[1]

The MUE System

If the number of units of service billed by the same physician for the same patient on the same day exceeds the maximum number permitted by the CMS, the Medicare Administrative Contractor (MAC) will deny the code or return the claim to the provider for correction (return to provider [RTP]). Units of service billed in excess of the MUE will not be paid, but other services billed on the same claim form may still be paid. In the case of an MUE-associated RTP, the provider should resubmit a corrected claim, not an appeal; however, an appeal is possible in the case of an MUE-associated denial. An MUE-associated denial is a coding denial, not a medical necessity denial; therefore, the provider cannot use an Advance Beneficiary Notice to transfer liability for claim payment to the patient.

MUE Adjudication Indicators

In 2013, the CMS modified the MUE process to include 3 different MUE adjudication indicators (MAIs) with a value of 1, 2, or 3 so that some MUE values would be date of service edits rather than claim line edits.[2] Medically Unlikely Edits for HCPCS codes with an MAI of 1 are identical to the prior claim line edits. If a provider needs to report excess units of service with an MAI of 1, appropriate modifiers should be used to report them on separate lines of a claim. *Current Procedural Terminology* (*CPT*) modifiers such as -76 (repeat procedure or service by the same physician) and -91 (repeat clinical diagnostic laboratory test) as well as anatomic modifiers (eg, RT, LT, F1, F2) may be used, with modifier -59 (distinct procedural service) used only if no other modifier suffices. An example of an MUE with an MAI of 1 is *CPT* code 17264 (destruction, malignant lesion [eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement], trunk, arms or legs; lesion diameter 3.1–4.0 cm), for which the MUE threshold is 3, meaning no more than 3 destructions can be submitted per claim line without triggering an edit-based rejection or RTP.

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This article provides general information. Physicians should consult *Current Procedural Terminology (CPT)* guidelines, state regulations, and payer rules for coding and billing guidance relevant to specific cases. The opinions represented here are those of the author and have not been reviewed, endorsed, or approved by the American Medical Association, the American Academy of Dermatology, or any other coding or billing authority.
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An MAI of 2 denotes absolute date of service edits, or so-called "per day edits based on policy." Such edits are in place because units of service billed in excess of the MUE value on the same date of service are considered to be impossible by the CMS based on regulatory guidance or anatomic considerations.[2] For instance, although the same physician may destroy multiple actinic keratoses in a single patient on the same date of service, it would not be possible to code more than one unit of service as *CPT* code 17000, which specifically and exclusively refers to the first lesion destroyed. Similarly, *CPT* code 13101 (repair, complex, trunk; lesion diameter 2.6–7.5 cm) could only be reported once that day, as all complex repairs at that anatomic site must be summed and smaller or larger totals would be reported with another code.

Anatomic limitations are sometimes obvious and do not require specific coding rules. For example, only 1 gallbladder can be removed per patient. Although Qualified Independent Contractors and Administrative Law Judges are not bound by MAIs, they do give particular deference to an MAI of 2 given its definitive nature.[2] Because ambulatory surgical center providers (Medicare specialty code 49) cannot report modifier -50 for bilateral procedures, the MUE value used for editing is doubled for HCPCS codes with an MAI of 2 or 3 if the bilateral surgery indicator for the HCPCS code is 1.[3]

An MAI of 3 describes less strict date of service edits, so-called "per day edits based on clinical benchmarks."[2] Similar to MAIs of 1, MUEs for MAIs of 3 are based on medically likely daily frequencies of services provided in most settings. To determine if an MUE with an MAI of 3 has been reached, the MAC sums the units of service billed on all claim lines of the current claim as well as all prior paid claims for the same patient billed by the same provider on the same date of service. If the total units of service obtained in this manner exceeds the MUE value, then all claim lines with the relevant code for the current claim will be denied, but prior paid claims will not be adjusted. Denials based on MUEs for codes with an MAI of 3 can be appealed to the local MAC. Successful appeals require documentation that the units of service in excess of the MUE value were actually delivered and demonstration of medical necessity.[2] An example of a *CPT* code with an MAI of 3 is 40490 (biopsy of lip) for which the MUE value is 3.

Complications With MUE and MAI

Because MUEs are based on current coding guidelines as well as current clinical practice, they are only applicable for the time period in which they are in effect. A change made to an MUE value for a particular code is not retroactive; however, in exceptional circumstances when a retroactive effective date is applied, MACs are not directed to examine prior claims but only "claims that are brought to their attention."[2]

It also is important to realize that not all MUEs are publicly available and many are confidential. When claim denials occur, particularly in the context of multiple units of a particular code, automated MUE edits should be among the issues that are suspected. Physicians may resubmit RTP claims on separate lines if a claim line edit (MAI of 1) is operative. An MAI of 2 suggests a coding error that needs to be corrected, as these coding approaches are generally impossible based on definitional issues or anatomy. If an MUE with an MAI of 3 is the reason for denial, an appeal is possible, provided there is documentation to show that the service was actually provided and that it was medically necessary.

Final Thoughts

Dermatologists should be vigilant for unexpected payment denials, which may coincide with the implementation of new MUE values. When such denials occur and MUE values are publicly available, dermatologists should consider filing an appeal if the relevant MUEs were associated with an MAI of 1 or 3. Overall, dermatologists should be aware that many MUEs that were formerly claim line edits (MAI of 1) have been recently transitioned to date of service edits (MAI of 3), which are more restrictive.

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