Dermatology Coding Alert

News You Can Use: Medically Unlikely Edits Improve Your Accuracy, Ease Claims Processing

Look for automatic limits on services you can bill in a 24-hour period.

Beginning in January 2007, you have a new set of "edits"--separate from the already-established National Correct Coding Initiative (NCCI) edits--from Medicare. If the newly launched edits function as intended, you should see fewer denials for clerical or software errors in your claims and quicker reimbursement for your physician's services.

Bone Up on the New MUEs

Background: The new "Medically Unlikely Edits" (MUEs) are an undated and refined version of the "Medically Unbelievable Edits" that the Centers for Medicare & Medicaid Services initially proposed--and then, due to provider concerns, withdrew--in 2005.

The goal: The new edits are designed to prevent overpayments caused by gross billing errors, usually a result of clerical or billing systems' mistakes, said **Niles Rosen**, medical director for Correct Coding Solutions--which has worked with CMS to develop the current edits--during a presentation at the American Medical Association's CPT and RBRVS 2007 Annual Symposium in Chicago.

What it means to you: "The MUEs will limit automatically the number of units of service you can bill in any 24-hour period," Rosen said.

Key advantage: If you do run afoul of the MUEs, you won't face denial for your entire claim, but only the single line item that violates the MUE guidelines, Rosen said.

Learn Anatomical Edits First

The first batch of MUEs will focus on anatomically impossible claims, and CMS will phase in other edits over time.

Example: The MUEs would limit the number of simple repair codes (12001-12021) per anatomic location that you may bill per claim. Therefore, you would never code for simple repairs of the face using both 12011 (Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less) and 12015 (...7.6 to 12.5 cm) for the same patient during the same session. Instead, you would add the lengths of the various repairs and report a single unit of service, such as 12016 (...12.6 to 20.0 cm).

Also, the edits will limit the claims for 99304 (Initial nursing facility care, per day ...) to a single unit per calendar day. This makes sense because 99304 is a "per day" code, experts say.

Bilateral coding: Other forthcoming MUEs will limit codes according to CMS policy. For example, ophthalmology biometry code 76516 has a bilateral indicator of "2," so you should never bill two or more units of this code, Rosen said.

Important: If an SNF resident is still covered under Part A, the services you provide are subject to consolidated billing under the Prospective Payment System (PPS). This means Medicare pays the SNF for all of the services it provides and you have to contract with the SNF to get paid.

You can't bill Medicare directly for technical components of diagnostic procedures provided for SNF patients, even if done in the physician's office. You must bill Part A through the SNF under PPS. In order to be paid, your practice must bill the

SNF and have a prearranged agreement that the SNF will pay the physician.

Once the patient exhausts his Part A benefits (having been at the SNF for more than 100 days following the hospital visit) or if he fails to meet CMS' Part A level-of-care requirements, the patient is in a Part B stay as a nursing facility patient and services aren't subject to consolidated billing. You should be able to bill Medicare directly for all components of diagnostic testing, as long as you have a physician order and medical necessity.

In addition: Other edits will focus on the nature of the equipment for testing, the study or procedure, or pathology specimen. So, for example, you can't bill more than one unit of a 24-hour study per day.

Appeal MUE Denials in These Cases

You will be able to appeal MUE edit rejections if you think that your claim meets the requirements of medical necessity. "Those individuals who are responsible for posting payments will have to be on alert for unusual denials," says **Cindy Parman, CPC, CPC-H, RCC,** co-owner of Coding Strategies Inc. in Powder Springs, Ga., and president of the American Academy of Professional Coders' National Advisory Board.

Bonus: "We have designed the edits such that there should be an absolute minimum of inappropriately rejected claims. The criteria we use are meant to catch egregious errors, not to prevent legitimate services from being paid," Rosen said.

Updates: Like the NCCI edits, MUEs will be updated quarterly and be subject to continuing refinement.

Don't wait for a denial: If your physician really has a patient with an anatomic abnormality, you should contact your carrier in advance instead of waiting to appeal a denial based on the MUEs.

Heads up: The MUEs won't be published or posted on the CMS Web site, CMS sources say. Medical Office Billing & Collections Alert will keep you updated if the MUEs are published.