Part B Insider (Multispecialty) Coding Alert

MUEs: Citing Misuse, CMS Changes MUE Rules for Several Bilateral Procedures

Unless modifier 50 works on your code, you're out of luck.

If you're one of the many coders that has surreptitiously bypassed the medically unlikely edits (MUEs) for bilateral procedures, your luck has run out. CMS has caught onto the fact that many practices are using the RT and LT modifiers (or separate line items with no modifiers at all) to avoid edits on modifier 50, and has instituted new screening edits to ensure that your claims get kicked out when bilateral billing isn't allowed on a particular code.

Background: If you report a bilateral procedure when the term "bilateral" is not included in the code's CPT® descriptor, both the Medicare Claims Processing Manual and the CCI manual dictate that you must report the code on a single line item with modifier 50 (Bilateral procedure) appended. If, however, a code is barred from being billed bilaterally due to the MUEs, Medicare will deny all claims with that code that has modifier 50 appended to it. To get around these MUEs, however, some practices have been getting a bit crafty, CMS says in MLN Matters article SE1422.

"At the recommendation of the OIG, CMS has examined its claim data relative to the MUE levels and has confirmed a pattern of inappropriate billing using multiple lines to bypass the MUEs," CMS says in the article. "Agreeing with the OIG that this practice overcharges both beneficiaries and the Medicare program, CMS is converting most MUEs into per-day edits."

What this means: Certain codes that were previously not allowed bilaterally but were easily bypassed by placing the codes on separate line items will now be billable only once per day based on MUEs. The "once per day" edit is commonly used on procedures such as appendectomies, since a doctor would almost never perform those more than once on any given day. However, CMS has firmly stated that this will be extended to cover additional procedures that you shouldn't bill bilaterally.

Resource: You can find the per-day edits on the CCI website at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html. They are identified by a MUE adjudication indicator of "2" or "3." For example, 27006 (Tenotomy, abductors and/or extensor[s] of hip, open [separate procedure]) is now a "per day" code effective July 1 due to its MAI indicator of "2." Of course, there could be rare occasions when you do perform bilateral hip tenotomies, but in those cases you'll have to appeal and even then, you may be out of luck.

"In the rare instances where the provider has verified all information, including the correct interpretation of coding instructions, and still believes that the correctly coded medically necessary service exceeds the MUE, the provider should submit a clearly supported appeal," CMS says in the article.

If you believe you submitted claims with two units of service rather than billing a single code on one line with modifier 50 appended as CMS requires, then you can request a reopening to address your error, the article notes. "Most importantly, though, the provider should bring his billing into compliance with CMS instructions, using one unit of service and the 50 modifier to avoid future denials and delays in payment," the agency says in the document.

Resource: To read CMS's MLN Matters article SE1422, visit www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1422.pdf.