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Part B Insider (Multispecialty) Coding Alert

Part B Mythbuster: Overcome Medically-Unlikely Edit Denial Challenges by Busting 4 Myths

If you ignore the medically unlikely edits, you're asking for a denial.

If you're receiving denials from Medicare, one possibility is that you're running up against medically unlikely edits (MUEs). The edits, which are designed to prevent overpayments caused by gross billing errors, usually a result of clerical or billing systems' mistakes, often confuse even veteran coders.

Ensure you're not letting MUEs wreak havoc on your urology practice's coding and reimbursement by uncovering the truth about four aspects of these edits.

Myth 1: MUE Edits Don't Affect Your Practice

Some practices feel that they don't need to worry about MUEs.

Reality: While you shouldn't stress too much, any practice filing a claim with Medicare should know what MUEs are and how they work.

"They limit the frequency a CPT code can be used," says **Chandra L. Hines,** business office manager at Capital Urological Associates in Raleigh, N.C. "With our specialty of urology, we need to become aware of the denials and not let every denial go because the insurance company said it was an MUE. We should all be aware of MUEs as they occur, and we cannot always control whether or not we will receive payment."

The MUE list includes specific CPT or HCPCS codes, followed by the number of units that CMS will pay. CMS developed the MUEs to reduce paid claims error rates in the Medicare Program. The first edits were implemented in January 2007, although the edits themselves became public in October 2008.

Some MUEs deal with anatomical impossibilities while others edit automatically the number of units of service you can bill for a service in any 24-hour period. Still others limit codes according to CMS policy. For example, excision of a hydrocele, bilateral (55041) has a bilateral indicator of "2," so you should never bill two or more units of this code. Additional edits focus on the nature of the equipment for testing, the study or procedure, or pathology specimen.

Anatomical example: The MUEs edit out and deny an erroneously coded claim for a circumcision (54161, Circumcision, surgical excision other than clamp, device or dorsal slit; older than 28 days of age) for a patient who has had a previous total penectomy (54125, Amputation of penis; complete).

Unit of service example: The edits also 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.

Note: While CMS updates the MUE list every quarter, just like the Correct Coding Initiative (CCI) edits, it does not publish all MUEs. The published MUE list consists of most of the codes with MUE values of 1-3, but CMS does not publish all MUE values that are 4 or higher.

You can find the published edits on the CMS Web site. You can find a link to the MUEs and the MUE FAQs at http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp.

Myth 2: You Can Bill the Patient to Overcome MUE Limits

Some practices believe that by having the patient sign an advance beneficiary notice (ABN) you can pass on the cost of

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procedures you know will be denied due to MUEs.

Reality: You cannot use ABNs to transfer responsibility for payment to the beneficiary.

CMS makes this rule very clear in its FAQs (http://questions.cms.hhs.gov), stating: "A provider/supplier may not issue an ABN for units of service in excess of an MUE. Furthermore, if services are denied based on an MUE, an ABN cannot be used to shift liability and bill the beneficiary for the denied services. It is a provider/supplier liability."

Myth 3: You Can Never Override an MUE

Don't think that even if your doctor performs a legitimate, medically necessary procedure that violates MUE edits, you can't override the edits.

Reality: CMS states that MUEs reflect the maximum number of units the vast majority of properly reported claims for a particular code would have, so you shouldn't need to override them often. But you can override an MUE when your doctor performs and documents a medically necessary number of services that exceed the limit. Check your payer's reporting preference.

How it works: HCPCS offers modifier GD (Units of service exceeds medically unlikely edit value and represents reasonable and necessary services). But there is little information available on proper use of this modifier.

A CMS FAQ states that "since each line of a claim is adjudicated separately against the MUE value for the code on that line, the appropriate use of Current Procedural Terminology (CPT) modifiers to report the same code on separate lines of a claim will enable a provider/supplier to report medically reasonable and necessary units of service in excess of an MUE value."

CMS notes that modifiers 76 (Repeat procedure by same physician) and 77 (Repeat procedure by another physician) are among your options, as are the anatomical modifiers, such as RT (Right side). You may also use modifier 59 (Distinct procedural service), but you should only use this if no other modifier is appropriate.

You also may need to supply documentation showing medical necessity for the additional units.

Myth 4: You Can't Appeal an MUE Denial

If your practice receives a denial based on an MUE, you may think that you cannot appeal that denial.

Reality: If you receive back a claim that is denied due to MUEs, you can appeal. "You can appeal the claims and you can address inquiries regarding the rationale for an MUE," Hines says. The caveat: "You may not receive the answer you want, and it will take a while to receive your response," she adds.

You should follow three steps during the appeals process:

Step 1: Determine the reason for the denial. First, figure out if you made a coding or billing error. If you find a coding error -- such as the wrong number of units entered in the units box -- submit a corrected claim. If you don't find a coding or billing error, move on to the next step.

Step 2: Decide if you have a legitimate reason to appeal. If you believe there is medical necessity for the services over and above the allowable under the MUE, you should appeal to the contractor. If there is no medical necessity, take a look again at coding. Make sure service is coded properly, and appropriate modifiers have been assigned.

Step 3: Appeal the claim. File an initial appeal with your carrier and follow the standard five-level Medicare appeals process. If appealing the claim due to a clinical reason, you may wish to employ clinical expertise when putting together your appeal letter.

Tip: Scrutinize your explanation of benefits (EOBs) to look for remark code N362. This remark code represents "the number of days or units of service exceeds our acceptable maximum" and may mean your claim has fallen afoul of the

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MUEs.

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