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BY AAPC

Part B Insider (Multispecialty) Coding Alert

Reimbursement: Sidestep Denials With 4 MUE Facts

Boost Medicare claims with medically unlikely edit know-how.

If your Part B practice keeps getting hit with denials from your MAC for undetermined reasons, the culprit may be confusion over medically unlikely edits (MUEs). The edits, which are designed to prevent overpayments caused by serious billing errors, often confound even the most seasoned coders.

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

Fact 1: MUE Edits Limit Frequency

Any practice filing a claim with Medicare should know what MUEs are and how they work, because these coding edits limit the frequency a CPT® code can be used. Understanding MUEs allows you to better pinpoint when a claim is denied due to these edits versus those claims that should have been paid. This will better allow you to identify when you should heed an insurance company's denial for an MUE, and when you should appeal.

The MUE list includes specific codes, followed by the number of units that Medicare payers will pay. The Centers for Medicare & Medicaid Services (CMS) developed the MUEs to reduce paid claims error rates in the Medicare Program, implementing the first edits due to MUE errors in 2007.

Some MUEs deal with anatomical impossibilities, while others automatically edit 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.

Anatomical example: CMS limits you to reporting just one unit of 31231 (Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)), so if you bill two units, the second unit will be denied. Many coders will note that the descriptor already says, "unilateral or bilateral," which should already be an indication that you can only report one unit of the code per session.

Bilateral example: CMS limits payment of traditional FESS codes (31254-31288) to one unit, with a MUE of 1 per day. But since the anatomy is bilateral, surgeons may perform these services on each sinus, once on the left and once on the right. However, because bilateral reporting of these codes is done with one line, for example, a bilateral total ethmoidectomy is reported as 31255-50. Reporting the bilateral service on one line with modifier 50 meets the requirements of a single unit, or a MUE of 1, and therefore, is payable at 150 percent. But if the bilateral procedure was billed over two lines, the MUE of 1 would be exceeded and the second side would not be reimbursed. This shows why it is so important that codes that can be reported bilaterally are billed on a single line with modifier 50.

Unit of service example: The edits also limit the units you can report 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. The same edit applies to 99231-99233 for subsequent hospital visits, for example, as you can only bill one visit per day.

Fact 2: You Can't 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 procedures you know will be denied due to MUEs.

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

CMS makes this rule very clear in its FAQs, stating: "ABN issuance based on an MUE is NOT appropriate. A denial of services due to an MUE is a coding denial, not a medical necessity denial. The presence of an Advance Beneficiary Notice (ABN) shall not shift liability to the beneficiary for units of service denied based on an MUE." Because the denial is not due to medical necessity, an ABN is not applicable.

Fact 3: In Some Cases, You Can Override an MUE

In certain situations, if your physician performs a legitimate, medically necessary procedure that violates MUE edits, you may be able to still get paid, despite the MUE.

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 in very specific circumstances, you can override an MUE when your physician performs and documents a medically necessary number of services that exceed the limit. Check your payer's reporting preference.

The MUE table includes a column for "MUE Adjudication Indicator" (MAI), which provides guidance about what circumstances allow you to override an MUE limit for a given code. If the code has an MAI of "1," the code is adjudicated on a claim-line basis, meaning that you can't exceed the number of MUE units on a claim line. You are allowed to use one of the distinct-service modifiers (such as modifier 59 or the "X" modifiers) to override the edit, if circumstances warrant.

An MAI of "2" means that the frequency limit is absolute for a date of service - you cannot override the edit with a modifier.

An MAI of "3" means that the frequency limit is based on the date of service, and Medicare will automatically deny any claims in excess of that limit, even if you use an appropriate modifier. However, Medicare will consider an appeal with appropriate documentation. You also may need to supply documentation showing medical necessity for the additional units.

Fact 4: You Can 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 a claim denial due to MUEs, you can appeal the claims and you can address inquiries regarding the rationale for an MUE. The caveat: You may not receive the answer you want, and it will take a while to receive your response. If you choose this route, follow three steps during the appeal 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 the service is coded properly, and that appropriate modifiers have been assigned.

Step 3: Appeal the claim. File an initial appeal with your carrier and follow the standard 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: When working to determine whether your claims have been denied due to MUE issues, scrutinize your remittance advice 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 MUEs.

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You can also use MUEs to assist you with appeals. Sometimes a submitted CPT® code may get denied with an indicator that it cannot be billed more than once in a day. For example, there are otolaryngology practices getting denials for 30117 (Excision or destruction (eg, laser), intranasal lesion; internal approach). Typically, you cannot use modifier 50 with 30117 for bilateral reporting. So, when two lesions are excised or destroyed, the XS or 59 modifier is required. The MUE for 30117 is 2, which means that for Medicare, the CPT® code is payable twice in one day.

A biller can use the fact that the CMS-established MUE for this CPT® code is 2 to appeal denials of the second instance of this code in a single day, even for non-Medicare payers, as the MUEs are part of the HIPAA standard transaction data set. The HIPAA standard transaction data set does not just refer to the CPT® codes. It includes most of the information included in the CMS fee database.

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