

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



2015 GEMs, Reimbursement Mappings, and ICD-10 Files Now Available -The 2015 General Equivalence Mappings (GEMs), Reimbursement Mappings, ICD-10-CM files, and ICD-10-PCS files are now available on the [2015 ICD-10-CM and GEMs](#) web page and [2015 ICD-10-PCS and GEMs](#) web page. The mappings can be used to convert policies from ICD-9-CM to ICD-10 codes. The GEMs provide both forward (ICD-9-CM to ICD-10) and backward (ICD-10 to ICD-9-CM) mappings. There are no new, revised, or deleted ICD-10-CM or ICD-10-PCS codes.

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Medically Unlikely Edits (MUE) and Bilateral Procedures

Provider Types Affected

This MLN Matters® Special Edition Article is intended for all Medicare Fee-For-Service (FFS) physicians, non-physician practitioners, providers, and other health care professionals who bill Medicare Administrative Contractors (MACs) for bilateral surgical procedures for Medicare beneficiaries.

Provider Action Needed



STOP – Impact to You

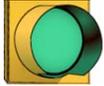
Claims filed using noncompliant coding for bilateral surgical procedures may have been paid in the past. The purpose of this article is to inform providers that MUE changes may now render those claim lines unpayable.

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**CAUTION – What You Need to Know**

Providers and suppliers, other than ambulatory surgical centers (ASCs), are reminded that Medicare billing instructions require claims for certain bilateral surgical procedures to be filed using a -50 modifier and one unit of service (UOS).

**GO – What You Need to Do**

Make sure your billing staffs examine their process for filing claims for bilateral procedures and services to ensure the -50 modifier is used in accordance with Medicare correct coding and claims submission instructions.

Background

There are several ways that claims for bilateral procedures could be coded, but different methods are only correct in specific situations. The most common methods involve reporting

- a single UOS on one line using the -50 modifier;
- one UOS on each of two lines using modifiers RT and LT; and
- two UOS on a single line with no modifier.

For Medicare claims, when reporting bilateral surgical procedures using codes where the term bilateral is not included in the descriptor, both the "Medicare Claims Processing Manual" and the National Correct Coding Initiative (NCCI) manual specify that these bilateral surgical procedures should be reported using a single UOS and the -50 modifier. The NCCI manual goes on to warn that MUE edits are predicated on the assumption that claims are coded in accordance with these Medicare instructions. Consequently many bilateral procedures have an MUE value of 1, and have had that MUE value for some time.

At the recommendation of the Office of the Inspector General (OIG), the Centers for Medicare & Medicaid Services (CMS) has examined its claims data relative to MUE levels and has confirmed a pattern of inappropriate billing using multiple lines to bypass the MUEs. Agreeing with the OIG that this practice overcharges both beneficiaries and the Medicare program, CMS is converting most MUEs into per day edits. The MUE Adjudication Indicator (MAI) indicates the type of MUE and its basis. Effective with the July 1, 2014 update, published per day edits are identified on the CMS NCCI website (<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html>) by their MAI value of 2 or 3.

MAI of 3

An MAI of 3, the most common per day edit, indicates an edit for which the MUE is based on clinical information such as

- billing patterns;
- prescribing instructions; or

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- other information.

It acknowledges that exceptions could occur but they would be sufficiently rare that the abnormally high units of service value should be considered to be a billing error.

Providers should carefully assess any denials based on these edits and consider the denial to be an indication of incorrect reporting due to such things as clerical errors or errors in the interpretation or application of coding instructions. It is also possible some provider reporting errors could be associated with a lack of medical necessity for the excess units, although the MUE itself does not address medical necessity, but only the medically unlikely nature of the reported value.

In the rare instance 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.

MAI of 2

An MAI of 2 indicates an edit for which the MUE is based on regulation or subregulatory instruction (“policy”), including the instruction that is inherent in the code descriptor or its applicable anatomy.

Examples:

1. The MUE of a “per cervical vertebra” code cannot exceed 7 based on anatomic considerations, that is, the number of cervical vertebrae. The MUE of 7 is therefore inherent in the code descriptor, an integral part of the code set specified for use by Health Insurance Portability & Accountability Act of 1996 (HIPAA).
2. The MUE of a “first 15 minutes” session code for a practitioner cannot exceed 1 since any time beyond that would require a different “subsequent” code, and that limitation is inherent in the code descriptor and its annual incorporation by CMS.

CMS expects all claims reporting services in excess of the MUE for edits with an MAI of 2 will represent either clerical errors or errors in the interpretation of instructions. CMS has not identified any instances in which a higher value would be correct and payable. MACs have therefore been instructed that this subregulatory instruction is binding on the MAC for both initial determinations and redeterminations, as is all subregulatory instruction.

Request for Reopening of a Claim

For all MUE edit denials, including both MAI of 2 and 3, if the provider identifies a clerical error and the correct value is equal to or less than the MUE, the provider may request a reopening to correct its billing of the claim as an alternative to filing an appeal. Providers are reminded this approach is allowable to redress underpayments resulting from unintentional errors, but it nonetheless delays full payment. For example, if the provider identifies a denial of a bilateral service because it was billed with two UOS instead of being billed with one UOS and a -50 modifier, the provider may request a reopening to correct the coding/billing error, although providers should be aware that reopening requests do not extend the window for filing

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appeals. More importantly, though, the provider should bring his billing into compliance with CMS instructions, using one UOS and the -50 modifier to avoid future denials and delays in payment.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net-work-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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