Audio Title: Medically Unlikely Edits (MUE) and Bilateral Procedures
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Welcome to Medicare Learning Network® Podcasts at the Centers for Medicare and Medicaid Services, or "CMS." These podcasts are developed and produced by the Medicare Learning Network® within CMS, and they provide official information for health care professionals.

If you submit claims to Medicare Administrative Contractors, or MACs, for bilateral surgical procedures for Medicare beneficiaries then you will benefit from this podcast. This podcast is intended for physicians, non-physician practitioners, providers, and other health care professionals.

This podcast, based on MLN Matters® Article SE1422, clarifies that while claims filed using noncompliant coding for bilateral surgical procedures may have been paid in the past, Medically Unlikely Edits, or MUE changes may now render those claim lines unpayable.

Providers and suppliers, other than ambulatory surgical centers, or ASCs, are reminded that Medicare billing instructions require claims for certain bilateral surgical procedures to be filed using a -50 modifier and 1 unit of service, or UOS.

Make sure your billing staff examines 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.

Let's discuss the background for this MUE change. There are several ways to code claims for bilateral procedures, but different methods are only correct in specific situations. The most common ways involve reporting the following three (3) methods:

First – a single UOS on one line using the -50 modifier;

Second – one UOS on each of two lines using modifiers RT and LT; and

Third – 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", or NCCI, manual state 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 based on the assumption that claims are coded in accordance with these Medicare instructions. So, 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, or OIG, CMS has examined its claims data related 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, or MAI, shows the type of MUE and its basis. Effective July 1, 2014, published per day edits are identified on the CMS NCCI website by their MAI value of 2 or 3. Please see page two of the MLN article SE1422 for the specific location of the NCCI website.

Next, let's discuss an MAI of 3. An MAI of 3, the most common per day edit, shows an edit where the MUE is based on clinical information such as billing patterns, prescribing instructions, or other information. It recognizes that exceptions could occur but they would be rare enough that the abnormally high units of service value should be considered to be a billing error.

You should carefully assess any denials based on these edits and consider the denial to be a sign 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 lack of medical necessity, but only the medically unlikely nature of the reported value.

In the rare instance where the provider has verified all information, including correctly interpreting coding instructions, and still believes that the correctly coded medically necessary service exceeds the MUE, the provider should submit a clearly supported appeal.

Now, we'll discuss an MAI of 2. An MAI of 2 indicates an edit where the MUE is based on regulation or policy, including the instruction that is characteristic in the code descriptor or its applicable anatomy.

There are two examples of this on page three of the article. In the first example, the MUE of a "per cervical vertebra" code cannot exceed 7 based on anatomic respects, that is, the number of cervical vertebrae. The MUE of 7 is therefore characteristic in the code descriptor, a basic part of the code set indicated for use by the Health Insurance Portability & Accountability Act of 1996, or HIPPA.

In the second example, 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 characteristic in the code descriptor and its annual addition by CMS.

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

Next, we'll discuss a request for reopening a claim. For all MUE edit denials, including both MAI of 2 and 3, if you identify a clerical error and the correct value is equal to or less than the MUE, you may request a reopening to correct your billing of the claim as an alternative to filing an appeal. Providers are reminded this approach is allowable to fix underpayments resulting from accidental errors, but it does delay full payment.

For example, if you identify a denial of a bilateral service because it was billed with 2 UOS instead of being billed with 1 UOS and a -50 modifier, you may request a reopening to correct the coding or billing error. Providers should be aware that reopening requests do not extend the window for filing appeals. More importantly, though, the provider should bring their billing into compliance with CMS instructions, using 1 UOS and the -50 modifier to avoid future denials and delays in payment.

There are some additional resources to guide you in your use of MUEs. The specific sites at which they can be found can be located on page two of SE1422.

To download the MLN Matters® Article SE1422, go to the CMS website at www.cms.gov and click on "Outreach and Education" at the top of the page. From that page, scroll down to the Medicare Learning Network section and click on the MLN Matters® Articles link. Follow the links to "2014 MLN Matters® Articles" and search for SE article number "SE1422."

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