



Medicare Part B

Medically Unlikely Edits - Billing the Correct Number of Units

NAS has become aware of some providers frequently billing excessive numbers of units on their Medicare claims. The claims processing system contains medically unlikely edits (MUEs) to prevent a medically unlikely number of services from being incorrectly paid.

However, NAS strongly urges providers to develop internal controls within the provider's organization to screen for these unlikely situations. The control can be as simple as a peer review, "double check" signoff that requires two billing or coding personnel to review number of units before a claim is submitted, or the control may be a software subroutine written to check the number of units is correctly entered before submission.

Whatever the methodology, it is in the provider's best interest to save time and money by making sure that the number of units per claim are entered correctly and do not exceed the CMS MUE guidelines.

MUE Background

In order to lower the Medicare fee-for-service paid claims error rate, the Centers for Medicare & Medicaid Services (CMS) established units of service edits referred to as Medically Unlikely Edits (MUEs). The National Correct Coding Initiative (NCCI) contractor develops and maintains MUEs.

- An MUE is defined as an edit that tests claim lines for the same beneficiary, Health Care Common Procedure Code System (HCPCS) code, date of service, and billing provider against a criteria number of units of service.
- The MUEs will auto-deny claim line items containing units of service billed in excess of the MUE criteria or Return to Provider (RTP) claims that contain lines that have units of service that exceed an MUE criteria.

Key Points

- Medicare contractors will deny the claim line or RTP claims with units of service that exceed MUE criteria and pay the other services on the claim as part of initial claims processing activities.
- The MUEs that are implemented by this notice are based on anatomic considerations. CMS believes that most MUEs based on anatomic considerations are not controversial, but CMS will allow and require an appeals process for those claim line items that are denied as a result of an MUE edit.
- An appeals process will not be allowed or required for claims that are RTP'd as a result of an MUE edit. Instead, providers should resubmit corrected claims.
- This set of MUEs that is based on anatomical considerations addresses approximately 2,800 codes.
- Excess charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a "provider liability"), and this provision can neither be waived nor subject to an Advance Beneficiary Notice of Noncoverage (ABN).

Additional Information

For complete details regarding CR 5402 please see the official instruction issued to your Medicare FI, Carrier or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R178PI.pdf> on the CMS web site.

For more information on MUEs and their effects on the Medicare claims processing process visit http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp on the CMS Web site.

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