

MEDICARE BILLING EDITS

A GUIDE TO REGULATION, RESEARCH, AND RESOLUTION



VALERIE A. RINKLE, MPA, AND DENISE WILLIAMS, COC

Medicare Billing Edits: A Guide to Regulation, Research, and Resolution

VALERIE A. RINKLE, MPA
DENISE WILLIAMS, COC

H3Pro
an H3.Group brand

Medicare Billing Edits: A Guide to Regulation, Research, and Resolution is published by HCPro, an H3.Group division of Simplify Compliance LLC.

Copyright © 2017 HCPro, an H3.Group division of Simplify Compliance LLC.

All rights reserved. Printed in the United States of America. 5 4 3 2 1

Download the additional materials of this book at www.hcpro.com/downloads/12623.

ISBN: 978-1-68308-593-5

No part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro or the Copyright Clearance Center (978-750-8400). Please notify us immediately if you have received an unauthorized copy.

HCPro provides information resources for the healthcare industry.

HCPro is not affiliated in any way with The Joint Commission, which owns the JCAHO and Joint Commission trademarks.

CPT copyright 2008 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

Valerie A. Rinkle, MPA, Author

Denise Williams, COC, Author

Nicole Votta, Editor

Andrea Kraynak, CPC, Product Manager

Erin Callahan, Vice President, Product Development and Content Strategy

Elizabeth Petersen, President, H3.Group

Matt Sharpe, Production Supervisor

Vincent Skyers, Design Services Director

Susan Robinson, Layout/Graphic Design

Zak Whittington, Cover Designer

Advice given is general. Readers should consult professional counsel for specific legal, ethical, or clinical questions.

Arrangements can be made for quantity discounts. For more information, contact:

HCPro

35 Village Road, Suite 200

Middleton, MA 01949

Telephone: 800-650-6787 or 781-639-1872

Fax: 800-639-8511

E-mail: customerservice@hcpro.com

Visit HCPro online at www.hcpro.com and www.hcmarketplace.com

Table of Contents

About the Authors	v
Valerie Rinkle, MPA.....	v
Denise Williams, COC.....	v
Introduction	1
What Are NCCI Edits?	2
How Edits Are Applied to Claims	3
Rationale for Edits.....	4
Physician and Provider Edits	5
Annual Policy Manual	6
How to Use This Book	7
Conclusion	7
Part 1: Types of Edits and Best Practices for Edit Management	9
Chapter 1: Types of NCCI Edits	11
PTP Edits	11
Add-On Code Edits	14
Medically Unlikely Edits.....	15
Chapter 2: Resolving Edits	19
Correct Coding Principles	19
AMA CPT vs. CMS Guidance	20
Modifiers	21
Edit Management and Charge Structure Considerations	23
Chapter 3: Best Practices for Edit Management	33
When to Apply Edits.....	33
Application of Edits to Payer Accounts	34

Research and Resolution of Edits	34
Claim Denials Due to Edits.....	36
Part 2: Examples and Applications of Best Practices.....	39
Chapter 4: Procedure-to-Procedure Edits.....	41
Inguinal Hernia Repair Example.....	43
Additional Examples	45
PTP Policies	53
Chapter 5: Add-On Code Examples.....	55
Bronchoscopy With Transbronchial Lung Biopsy.....	56
Drug Administration Services	56
Decalcification Procedure With Pathology Services	58
Add-On Code Policies.....	58
Chapter 6: Medically Unlikely Edit Examples	61
MUEs for Medications	62
MUEs for Procedures.....	65
MUE Policies	67
Appendix A: NCCI and MUE FAQs	69
Appendix B: Examples of MUE for 94640	
Emergency Department Visit	75

About the Authors

Valerie Rinkle, MPA

Valerie Rinkle, MPA, is a lead regulatory specialist and instructor for HCPro's Revenue Integrity and Chargemaster Boot Camp[®], as well as an instructor for HCPro's Medicare Boot Camp[®]—Hospital Version and Medicare Boot Camp[®]—Utilization Review Version. Rinkle is a former hospital revenue cycle director and has more than 30 years in the healthcare industry, including more than 12 years of consulting experience in which she has spoken and advised on effective operational solutions for compliance with Medicare coverage, payment, and coding regulations.

Denise Williams, COC

Denise Williams, COC, is senior vice president of the revenue integrity division and compliance auditor at Revant Solutions. She has more than 30 years of healthcare experience, including a background in multiple areas of nursing. For the past 20 years, Williams has been in the field of coding and reimbursement and has performed numerous evaluation and management, outpatient surgical, emergency department, and observation coding chart reviews from the documentation, compliance, and reimbursement perspectives. She serves as a contributing author to articles published in HCPro's Briefings on APCs and is a nationally recognized speaker on various coding and reimbursement topics.

Introduction

The intersection of the Centers for Medicare & Medicaid Services (CMS) packaged payment policy and the increasing volume of National Correct Coding Initiative (NCCI) edits can be likened to a car crash waiting to happen. Hospitals are having valid, medically necessary claim lines denied—including charges and units below medically unlikely edit (MUE) limits. Often, the Common Procedural Terminology® (CPT) code that is denied is packaged under the outpatient prospective payment system (OPPS); therefore, appealing the claim would result in no additional payment. However, what providers may not realize is that CMS does not use denied charge lines in their rate setting process, even if the line items and charges are for medically necessary services. The ultimate result is ever lower OPPS payment rates for outpatient hospital services.

Providers can help stop the crash by ensuring that their claims, CPT coding, medical necessity, and units are all correct. Once these items are verified, each provider must strategically decide whether there are valid options to revise billing for services that hit an NCCI edit or MUE, as is the case with many packaged services, versus whether denied services will be appealed. Finally, providers should consider increasing advocacy efforts with CMS around this complex issue.

What Are NCCI Edits?

The National Correct Coding Initiative (NCCI) is a CMS initiative begun in 1996 “to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims,” according to the *National Correct Coding Initiative Policy Manual for Medicare Services (NCCI Manual)*. The NCCI is maintained by a CMS contractor, Correct Coding Solutions, LLC. The CMS website instructs providers to address concerns regarding specific NCCI edits to the contractor rather than directly to CMS.

NCCI applies to Medicare Part B claims (both institutional and professional) and to Medicaid claims. Because of CMS’ requirements concerning charges, and due to the use of charges in apportionment of costs, gross charges should be applied consistently to all patients—Medicare and others. Therefore, NCCI edits should arguably be applied to all outpatient claims regardless of payer, because resolving the edits often results in removing or changing billed charges for a service. This method is the best, and maybe easiest, way to adhere to the requirement that charges be consistent across all patients regardless of payer source.

According to the *NCCI Manual*, the following resources are evaluated when an edit is identified:

- Current and past *NCCI Manual* provisions for the type of service
- CPT and HCPCS manual code descriptors
- Coding conventions defined in the *CPT Manual*
- Coding guidelines developed by national societies
- Analysis of standard medical and surgical practice
- Review of current coding practice
- Provider billing patterns

The last item—provider billing patterns—is critically important, because how providers collectively respond to edits affects future edits, particularly with MUE unit limits. If providers respond to edits incorrectly, CMS will not have accurate data on

which to base future edits, leading to edits that could actually be in error. Therefore, evaluating compliant and valid options for billing is extremely important to prevent the creation of additional edits that are, in part, based on the lack of provider response to or challenge of the edits. Provider silence is interpreted as agreement.

How Edits Are Applied to Claims

There are several sets of edits that are involved in adjudication of a claim. Originally called the Outpatient Code Editor (OCE), the Integrated Outpatient Code Editor (I/OCE) is the process by which outpatient institutional claims (UB-04/837I) are reviewed to determine the correct reimbursement for services. In 2007, CMS merged the processing of all institutional claims (OPPS and non-OPPS) through the same claims editor to create the I/OCE. Claims submitted by hospital outpatient departments, community mental health centers, and critical access hospitals now all process through the same editor. The I/OCE contains all of the edits that are applied to claims, including MUEs, NCCI edits, device-to-procedure edits, nuclear medicine-to-radiopharmaceutical edits, and modifier edits (e.g., modifier -25 applied to an evaluation and management service). The I/OCE applies the edits based on the dates of service on the claim and determines what services should be considered for reimbursement based on the Medicare billing rules. The I/OCE then applies the programmed reimbursement methodology to reimburse the institutional provider for the services reported (CMS, Outpatient Code Editor, 2017).

Noninstitutional providers submit professional claims (1500/837P) that are processed through a CMS program called the Multi-Carrier System (MCS). The MCS incorporates several different types of edits related to the Medicare Physician Fee Schedule (MPFS), including the NCCI edits applicable to professional claims (CMS, Medicare Contractors, 2006).

Rationale for Edits

The rationale for these edits is based on the intent of a claim. A claim is a series of alphanumeric and numeric codes that paint a picture of the services provided to a beneficiary (CPT and HCPCS codes) and the reasons these that services were provided (ICD-10-CM codes). The claim contains other codes (e.g., value codes, occurrence codes, dates of service) that further define the picture. To adjudicate a claim, it's necessary to have a process that takes the data submitted, combines it in an organized fashion, and produces a final outcome that triggers payment.

The Medicare Claims Processing Manual states that proper coding is necessary on Medicare claims because codes are generally used in determining coverage and payment amounts. Proper coding includes the actual use of codes to define procedures, units of service, and application of modifiers. HCPCS codes have been selected as the approved code set for reporting outpatient procedures on claims. HCPCS codes include the American Medical Association's (AMA) CPT codes, defined as Level I codes. Level II codes include alphanumeric codes primarily for items and nonphysician services that are not included in CPT, such as ambulance, durable medical equipment (DME), orthotics, and prosthetic supplies (DMEPOS). The Level II codes are maintained jointly by CMS, the Blue Cross and Blue Shield Association (BCBSA), and the Health Insurance Association of America (HIAA). Level III codes are considered local codes and may be approved and used for items and services not covered by any Level I or Level II code/modifier. They are alphanumeric and are restricted to the W, X, Y, and Z series (*Medicare Claims Processing Manual*, Chapter 4, 2017).

There are more than 7,000 service codes, plus titles and modifiers, in the Level I or CPT section of HCPCS, which is copyrighted by the AMA. CPT code descriptions include coding conventions, modifier instructions, coding guidelines, and other logic. The HCPCS Level II section also contains logic in the code descriptions. The HCPCS coding system is merely one of the tools used to achieve national consistency in claims processing, and NCCI is another tool applied to the HCPCS code set.

Introduction

A key CMS responsibility is to protect the Medicare Trust Funds and other public resources against losses from improper payments. Therefore, one major goal of CMS program integrity strategy is to implement prepayment edits to identify potential improper payments before they are made. Due to the sheer volume of codes and the complexity of coding conventions, CMS discovered that a lack of understanding and consistent application of the coding rules was resulting in significant program overpayments. This is one key rationale for the NCCI edits: to create consistent code reporting on claims, resulting in consistent and correct reimbursement for services. In the most recent report from CMS to Congress on its Medicare and Medicaid program integrity initiatives, CMS reported that systematic edits resulted in \$775.1 million in savings in 2015, up from \$758.1 million in 2013 (CMS, National Correct Coding Initiative Edits, 2017).

Clearly, there is much at stake from the perspective of CMS' program integrity efforts to prevent improper payments due to incorrect codes and units reported on claims.

Physician and Provider Edits

The *NCCI Manual* often uses the term “physician” when describing policies. Generally, the term does not restrict the policies to physicians but rather is used to apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes. However, in some sections, the term applies exclusively and specifically to physicians or other nonphysician practitioners for professional services billed on 1500/837P claims because the policy described does not apply to other types of entities. These are often collectively called professional services.

Providers or facilities reporting services under Medicare's hospital outpatient prospective payment system (OPPS) on UB-04/837I claims should report all services in accordance with appropriate Medicare instructions, including the HCPCS code set. These are often called provider or facility services (*NCCI Manual*, Chapter I, 2017).

For both professional and provider services, outpatient procedures should be reported with the most comprehensive HCPCS code that describes the services performed. Providers and professionals must not unbundle the services described by a more comprehensive HCPCS/CPT code. This is one of the coding conventions that NCCI attempts to include in its edits (*NCCI Manual*, Chapter I, 2017).

Annual Policy Manual

In addition to the actual code lists and edits, the *NCCI Manual* provides narrative explanations of many of the code edits applicable to different types of services. The *NCCI Manual* and edits may be downloaded from the CMS website. The manual includes 12 chapters. Chapter I describes general coding principles that summarize Medicare NCCI principles as well as CPT coding principles. Chapters II through XI follow the respective sections of the *CPT Manual*.

For example, Chapter II applies to anesthesia services (CPT codes 00000–09999), Chapter V applies to surgery, respiratory, cardiovascular, hemic, and lymphatic systems (CPT codes 30000–39999), and Chapter X applies to pathology and laboratory services (CPT codes 80000–89999). Chapter XII applies to Level II HCPCS codes (codes A0000–V9999). Each chapter describes numerous coding concepts and edits applicable to the codes in the code range described by the chapter and may also provide clinical examples to better explain the basis of the edits.

The *NCCI Manual* is updated annually. The code lists and tables are updated quarterly and loaded into the I/OCE and CMS claims systems and onto CMS' NCCI webpages. It is important to check that the correct code edits for the date of service are being applied to the claim. Edits are often retired or changed; therefore, it is important to continue reviewing them, especially for common and frequent services.

How to Use This Book

This book comes with additional downloadable resources, including the following:

- **An NCCI and MUE training webinar.** Both the MP4 and PDF files for this presentation are included for your use. Print out the PDF and tune in to the webinar on your own time, or use this resource to train staff by scheduling a time to view the presentation together and distributing the PDF to the team before beginning.
- **Information on finding and using NCCI PTP edit files and Addendum B of the OPPS.** These files are updated quarterly, and updates should be incorporated into processes and training.
- **Examples of MUEs and rate setting.** This document demonstrates the impact on CMS' rate setting of facilities adjusting charges to fit within MUE limits as opposed to correctly reporting and coding drugs when administered as medically necessary.
- **A PTP decision tree.** Use this flow chart to help determine how to handle PTP edits.
- **An MUE decision tree.** Use this flow chart to help determine how to respond to MUEs.

Conclusion

The remainder of this book will describe NCCI edits by type in more detail and will address best practices for edit management. Although they are framed from a provider or facility perspective, professionals can apply these best practices to their NCCI claim edits as well. Key to effective edit management is knowing what questions to ask when an edit occurs on a claim for a common set of codes that describe services provided. This book defines those questions. Then, to illustrate the application of these questions and best practices, the book provides common examples of edits and the process of applying the questions, answers, and other best

practices. Finally, this book concludes with downloadable resources that will support the application of best practices in edit management.

REFERENCES

Centers for Medicare and Medicaid Services (CMS). (2006). Medicare contractors. Retrieved from www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HIGLAS/downloads/MedicareContractor.pdf.

CMS. (2017). National Correct Coding Initiative Edits. Retrieved from www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

CMS. (2017). *National Correct Coding Initiative Policy Manual for Medicare Services*. Chapter 1. Retrieved from www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/2017-NCCI-Policy-Manual.zip.

CMS. (2017). Outpatient Code Editor. Retrieved from www.cms.gov/Medicare/Coding/OutpatientCodeEdit/.

Part 1

Types of Edits and Best Practices for Edit Management

Claims returned with National Correct Coding Initiative (NCCI) edits or medically unlikely edits (MUE) can easily be lost in the shuffle. Often, it's not clear who is responsible for resolving an edit. Delays with accounts receivable can hold up the process even longer. Properly addressing edits requires time and resources invested in research to identify the root cause, action to fix the source of the problem on the front end, and resolution attempts to avoid working the same edits repeatedly. In addition, specific actions may be required when handling edits from each individual payer. Edits may encompass different strategies for resolution depending on whether one department or multiple departments are involved. Resolving edits can quickly become an overwhelming project, and some hospitals may be leaving money on the table by writing off these claims.

A sound understanding of the types of NCCI edits, including when it is appropriate to use modifiers, a system for researching the root cause of common edits, and coordinated strategies for handling and addressing edits, can help turn the tide. Proper application of best practices can make edit resolution a routinely successful task.

Chapter 1

Types of NCCI Edits

Initially, the National Correct Coding Initiative (NCCI) was composed of comprehensive/component codes that are now referred to as procedure-to-procedure (PTP) edits. Later, add-on code edits were created following a Common Procedural Terminology® (CPT) coding convention where an initial, or primary, CPT code must be present before a secondary, or add-on, CPT code is added to or included on the claim. Lastly, the Centers for Medicare & Medicaid Services (CMS) developed medically unlikely edits (MUE). These are unit limits per CPT code based on the type of service and likelihood for more than one unit per date of service and for the same provider or professional.

The NCCI contains these three types of edits: PTP edits, add-on codes, and MUEs. Each type of edit has different causes, meanings, and impacts and should be analyzed and understood to address the specific causes of the edit. Knowledge of correct coding principles, including the proper use of modifiers, is necessary to understand edits and know, in part, how to avoid or resolve them.

PTP Edits

PTP edits are pairs of CPT and/or Healthcare Common Procedure Coding System (HCPCS) Level II codes that are not both separately payable when billed by the same provider for the same beneficiary for the same date of service, unless an appropriate modifier explaining an applicable circumstance is reported. PTP code pairs are separated into Column 1 codes and Column 2 codes. When a PTP code pair is reported without a modifier, the Column 1 code is processed for payment and

the line with the Column 2 code is rejected. The *National Correct Coding Initiative Policy Manual for Medicare Services (NCCI Manual)* indicates that the Column 2 code is denied; however, the processing logic of the Integrated Outpatient Code Editor (I/OCE) in the I/OCE specifications table indicates that the actual edit is a line item rejection (CMS, OCE Quarterly Release Files, 2017). Modifiers and Column 1 and Column 2 codes will be discussed in more detail later in this chapter.

The hospital-specific PTP edits are available in two files posted on the CMS website. The two files contain both the Column 1/Column 2 edits and the mutually exclusive edits (discussed later in this chapter). Each file contains roughly half the NCCI edits and is updated quarterly (CMS, PTP Coding Edits, 2017).

Column 1/Column 2

Column 1/Column 2 (formerly known as comprehensive/component) edits are generally designed to prevent unbundling of services via reported CPT/HCPCS codes. Sometimes a lesser service is included as a component of a more comprehensive service provided at the same session. Unbundling can be described as coding these services in a manner where they are coded and billed separately. Because the code for the comprehensive service has the cost of the component services built in, unbundling these services can generate separate or additional payment for the component service, which is already included in the payment for comprehensive service (CMS, *NCCI Manual*, Chapter I).

PTP edits are designed to prevent this situation from occurring. The more comprehensive service is in Column 1, and the lesser, or component, service is in Column 2.

In some cases, appending an NCCI modifier to a Column 2 code will override the NCCI edit and allow payment for both codes. CMS uses modifier indicators to show whether a modifier can be used to override a PTP edit and any restrictions that apply to the use of a modifier with a code pair (modifiers will be discussed in more detail in Chapter 2) (CMS, *NCCI Manual*, Chapter I).

Each set of PTP code pairs is assigned a modifier indicator. If the modifier indicator is 0, the edit will not be affected by reporting a modifier. In other words, in such cases, no modifier is allowed for the Column 2 code when reported with the Column 1 code. If the modifier indicator is 1, the edit may be overridden by reporting one of the NCCI modifiers on the Column 2 code. However, if the Column 2 code is reported without a modifier, edit 40 of the I/OCE rejects the line with the Column 2 code. Therefore, if the Column 2 code is reported, with or without a modifier, edit 20 of the I/OCE rejects the line with the Column 2 code. If the modifier indicator is 9, the edit has been removed from the NCCI and is displayed for historical purposes only (CMS, *NCCI Manual*, Chapter I, 2017; CMS, *How to Use Medicare National Correct Coding Initiative (NCCI) Tools*, 2016).

The rationale for the PTP edits is included in the CMS PTP Coding Edits file. See Figure 1.1 for a list of the different PTP edit rationales. These rationales can help explain whether a modifier is allowed or not and why the edit may be occurring.

✓	Anesthesia service included in surgical procedure
✓	CPT "separate procedure" definition
✓	CPT Manual or CMS manual coding instructions
✓	Gender-specific (formerly Designation of sex) procedures
✓	HCPCS/CPT procedure code definition
✓	Misuse of Column 2 code with Column 1 code
✓	More extensive procedure
✓	Mutually exclusive procedure
✓	Sequential procedure
✓	Standards of medical/surgical practice

Mutually exclusive procedure edits

Mutually exclusive procedures follow a specific type of edit rationale.

Mutually exclusive edits are designed to prevent separate payment for procedures that cannot reasonably be performed together based on the code definition or anatomic considerations. The *NCCI Manual* provides the following examples of scenarios where two services “cannot reasonably be done at the same session”:

- The repair of an organ by two different methods. One repair method must be reported for the repair.
- An initial service and a subsequent service. It is considered contradictory for a service to be classified as both an initial and a subsequent service at the same time (with the exception of drug administration services).

Unlike the other PTP edit rationales, with mutually exclusive edits, the more comprehensive code, which often is the higher-paying code, is in Column 2. The same modifier status indicators are used with mutually exclusive edits. However, due to the difference in the placement of the codes in Column 1 and Column 2, coders should carefully review the documentation to determine whether the Column 1 or Column 2 code more accurately describes the service if a modifier cannot be applied (CMS, *NCCI Manual*, Chapter I).

Add-On Code Edits

An add-on code describes a service that is always performed in conjunction with another primary service and is eligible for payment only when provided with an appropriate primary service. Add-on code edits are described in Chapter 1 of the *NCCI Manual*. Add-on codes are designated with a “+” symbol or the phrase “each additional” or “list separately in addition to the primary procedure” in the *CPT Manual* or *HCPCS Manual* in the code description or next to the code descriptor. If an add-on code is reported without the required primary procedure code, the claim will be returned to the provider for correction, according to the I/OCE specifications edit 84.

CMS publishes a file containing the add-on code edits on its NCCI website. The edits are updated in January and on a quarterly basis as necessary. Add-on codes are identified as type I, II, and III. Type I add-on codes have a limited number of identifiable primary codes. Type II add-on codes do not have a list of acceptable primary codes. Medicare Administrative Contractors (MAC) must develop a list of acceptable primary codes required for reporting and payment of type II add-on codes. Type III add-on codes have some, but not all, of the acceptable primary

codes identified. MACs must develop a list of additional acceptable primary codes for reporting and payment of type III add-on codes (CMS, Add-on Code Edits, 2017).

Add-on codes should be clearly identified in the chargemaster's charge descriptions. Furthermore, add-on codes and the criteria for the add-on code should be part of the charge trigger in the electronic medical record (EMR) documentation or other charge capture process. Setting it up this way will avoid a situation in which an add-on code is present without the associated primary code.

Add-on code edits should be applied during health information management (HIM) coding.

Medically Unlikely Edits

MUEs represent the maximum number of units reportable for a HCPCS code by the same provider for the same beneficiary for the same date of service or, at times, for the encounter as reported on a single claim. Chapter I of the *NCCI Manual* describes MUEs. CMS publishes an MUE file containing the MUE limits for some (but not all) HCPCS codes. The file is updated quarterly, and there is a separate file for practitioner, facility, and durable medical equipment services (CMS, Medically Unlikely Edits, 2017).

The MUE file contains a column with the rationale for each MUE. MUEs are based on the following considerations:

- Anatomic considerations (e.g., appendectomy)
- Code descriptions (e.g., a code with the term “initial” in its title)
- Established CMS policy (e.g., bilateral procedures)
- Nature of the analyte (e.g., 24-hour urine collection)
- Nature of the procedure and the amount of time required to perform the procedure (e.g., overnight sleep study)
- Nature of the item (e.g., wheelchair)

- Clinical judgment based on input from physicians and clinical coders
- Submitted claims data from a six-month period

The MUE file contains a column indicating whether an MUE will be applied by date of service or by claim line. All claim lines with the same CPT/HCPCS code on the same date of service will be added together and compared to the MUE value, regardless of modifier. The claim lines will be denied if the units collectively exceed the MUE value. Claim lines are totaled on the claim being edited and all prior paid claims with the same date of service for the same beneficiary and provider. For MUEs applied by date of service, CMS has assigned one of two MUE Adjudication Indicators (MAI) (CMS, *NCCI Manual*, Chapter I).

MUE adjudication indicators

MAIs are listed in the third column in the MUE table files on CMS' MUE webpage. The MAI describes the type of MUE (CMS, *How to Use NCCI Tools*, 2016).

An MAI of 1 indicates that the MUE is a claim line edit. Modifiers may be used as appropriate to report the code on separate lines. Each claim line with that code will be separately adjudicated against the code's MUE value. The use of modifiers could be limited by a MAC's rules (CMS, *NCCI Manual*, 2017).

An MAI of 2 is an absolute per-day edit based on policy. CMS uses this designation to indicate that it is impossible to report the code because doing so would violate a statute or regulatory or subregulatory guidance. This includes limitations that are inherent in anatomy or code descriptions (CMS, *NCCI Manual*, 2017).

An MAI of 3 indicates that the edit is based on clinical information, billing patterns, prescribing instructions, and other information. For edits with an MAI of 3, once the provider verifies the coding instructions and believes the units in excess of the MUE are correctly coded and medically necessary, the provider may submit an appeal (CMS, *NCCI Manual*, 2017).

Appealing MUEs

If a claim line with a HCPCS code subject to an MUE exceeds the MUE value, the line will be denied. CMS has assigned an MAI of 1 for MUEs applied by claim line (CMS, *NCCI Manual*, 2017; CMS, *Transmittal R1421OTN*, 2014).

Medically appropriate units of service in excess of an MUE may be reported on a separate line with an appropriate modifier. Because each line is edited against the MUE separately, the units on the separate line will process for payment. Line item denials for units in excess of an MUE are appealable denials.

It is extremely important that MUEs be appealed. The NCCI contractor relies on the previous six months of submitted claims data when determining MUE limits. If all providers edit their claims down to the acceptable MUE value, the NCCI contractor will determine that the value is likely too high and will further ratchet down the MUE limit. This results in a downward spiral of ever lower MUE values for services.

Appealing medically necessary MUE services may not seem like a valid use of resources, particularly if the HCPCS code does not result in separate payment if the appeal is upheld. However, without writing to the NCCI contractor to advocate for changing the edit or appealing medically necessary services, it is not likely that the NCCI contractor will change the MUE value. This is particularly true with drugs. For Medicaid or other payer accounts, the MUE unit limit may not be appropriate at all due to the fact that the NCCI contractor uses only Medicare fee-for-service claims in its analysis.

Chapter I of the *NCCI Manual* states “for others [drugs], there is a maximum ‘recommended’ or ‘usual dose.’” The NCCI contractor determines the daily recommended or usual dose calculation from claims data. For drug dosages dependent on patient weight, the *NCCI Manual* goes on to state, “If the maximum daily dose calculation is based on actual body weight, a dose based on a weight range of 110–150 kg was evaluated against the claims data.” This means that when a patient weighs over 150 kg and the therapeutic drug dosage ordered and administered to the patient reflects a dosage for weight above 150 kg, an MUE will be applied to the units

in excess of the dosage applicable to 150 kg. This is a perfect example of when an appeal should be filed, even if the drug is not separately paid.

Without numerous complaints formally filed with the NCCI contractor and appeals from hospitals to MACs and higher levels of appeal, the edits are likely to remain at values too low to reflect actual medical care.

REFERENCES

Centers for Medicare & Medicaid Services (CMS). (2016). How to Use National Correct Coding Initiative (NCCI) Tools. Retrieved from www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/How-to-Use-NCCI-Tools.pdf.

CMS. (2017). *National Correct Coding Initiative Policy Manual for Medicare Services*. Chapter I. Retrieved from www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/2017-NCCI-Policy-Manual.zip.

CMS. (2017). OCE Quarterly Release Files. Retrieved from www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.html.

CMS. (2017). PTP Coding Edits. Retrieved from www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html.

CMS. (2014). *Transmittal R14210TN*. Retrieved from www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2014-Transmittals-Items/R14210TN.html.

Total Estimated Cost of Encounter			\$ 650.00			\$ 149.25
Scenario #2 - Hospitals Remove Unit(s) in Excess of MUE & Leave Total Charges the Same						
99284	1/15/16	1	\$ 500.00	450	0.21021	\$ 105.11
94640	1/15/16	1	\$ 75.00	410	0.29431	\$ 22.07
9464076	1/15/16	2	\$ 150.00	410		
9464076	1/15/16	1	\$ 150.00	410	0.29431	\$ 44.15
Total Estimated Cost of Encounter			\$ 725.00			\$ 171.32
Scenario #3 - Hospitals Remove Entire Line with Unit(s) and Charges in Excess of MUE						
99284	1/15/16	1	\$ 500.00	450	0.21021	\$ 105.11
94640	1/15/16	1	\$ 75.00	410	0.29431	\$ 22.07
9464076	1/15/16	2	\$ 150.00	410		
Total Estimated Cost of Encounter			\$ 500.00			\$ 127.18

Below are the two main requirements for charges - to meet these requirements, the charge for the complete service should be reported in the same amount to all patient accounts.

“Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions” (PRM1, Chapter 22, Section 2202.4).

“...each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services” (PRM1, Chapter 22, Section 2203).

MEDICARE BILLING EDITS

A GUIDE TO REGULATION, RESEARCH, AND RESOLUTION

VALERIE A. RINKLE, MPA, AND DENISE WILLIAMS, COC

Claims returned with National Correct Coding Initiative edits or Medically Unlikely Edits can easily be lost in the shuffle. Often, it's not clear who is responsible for resolving an edit, and delays from other departments can hold up the process. Some hospitals may even be leaving money on the table by writing these claims off.

Medicare Billing Edits: A Guide to Regulation, Research, and Resolution will help readers understand Medicare claims edits and give them practical tools and information to efficiently and effectively handle these edits, helping to ensure compliance and protect revenue.

Nationally recognized experts **Valerie A. Rinkle, MPA**, and **Denise Williams, COC**, leverage their years of experience to explain the types and causes of common edits using case studies to illustrate how to successfully resolve edits and appeal denials.

HCPro
an H3.Group brand

100 Winners Circle, Suite 300
Brentwood, TN 37027
www.hcmarketplace.com

MBEGRRR

