



## Commercial Plans CODING FACT SHEET

### Medically Unlikely Edits (MUEs)

#### Description:

These edits audit professional claims using the Practitioner Services MUE table data published quarterly by CMS and found at <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE>. The rule allows payment of submitted quantities up to the MUE limit and denies the remainder.

Medically Unlikely Edits (MUE) are intended to limit the number of times a procedure can be billed on a single date of service. The Centers for Medicare and Medicaid Services (CMS) developed the MUE program to reduce the paid claims error rate for Part B claims. The limit reflects the total number of times it is clinically possible or clinically reasonable to perform a given procedure on a single date of service across all anatomic sites. Many commercial payers have also adopted the program for consistency and to control medical claim costs.

**BE AWARE of CMS restrictions on MUE limits.** Check the MUE Adjudication Indicator (MAI) on the appropriate CMS file before submitting excess units. Where a code's MAI = 2, CMS considers excess units as impossible and billing these units as contrary to Medicare statute, regulations, or guidance. Where a code's MAI = 3, excess units may be paid on formal appeal where medical necessity is proven.

#### Modifiers:

The medical record may demonstrate that units above the MUE limit are appropriate. **To expedite payment**, you may use modifiers (e.g., -59, -76, -77, -91, anatomic) to report reasonable and necessary units above the MUE limit as shown in the examples below.

#### Examples:

*For illustration purposes only: codes subject to change*

##### Claim #1

The medical record demonstrates that one additional unit for code 42500 (MUE limit = 2) is appropriate as a separate and distinct procedure.

| Line | Code  | Description                         | Units | Modifier | Result     |
|------|-------|-------------------------------------|-------|----------|------------|
| 1    | 42500 | PLASTIC REPAIR OF SALIVARY DUCT ... | 2     | None     | Line pays. |
| 2    | 42500 | PLASTIC REPAIR OF SALIVARY DUCT ... | 1     | -59      | Line pays. |

##### Claim #2

The medical record demonstrates that two additional units for code 87070 (MUE limit = 3) is appropriate as a repeat clinical laboratory test.

| Line | Code  | Description                            | Units | Modifier | Result     |
|------|-------|----------------------------------------|-------|----------|------------|
| 1    | 87070 | Culture bacterial any other source ... | 3     | None     | Line pays. |
| 2    | 87070 | Culture bacterial any other source ... | 2     | -91      | Line pays. |

#### Bilateral Procedures and MUE Limits:

Bilateral procedures submitted on two claim lines may generate an MUE limit denial. For example, code 27405 is a bilateral procedure with an MUE limit = 1. If submitted on two claim lines, the MUE edit applies:

| Line | Code  | Description                           | Units | Modifier | Result                                                                        |
|------|-------|---------------------------------------|-------|----------|-------------------------------------------------------------------------------|
| 1    | 27405 | Repair primary torn knee ligament ... | 1     | -LT      | Line pays, but NOT with bilateral adjustment because modifier 50 is excluded. |
| 2    | 27405 | Repair primary torn knee ligament ... | 1     | -RT      | Line denies because the MUE limit was reached on line 1.                      |

**To expedite payment**, submit the bilateral procedure as:

| Line | Code  | Description                           | Units | Modifier | Result                                                                               |
|------|-------|---------------------------------------|-------|----------|--------------------------------------------------------------------------------------|
| 1    | 27405 | Repair primary torn knee ligament ... | 1     | -50      | Line pays. Bilateral adjustment properly calculated due to inclusion of modifier 50. |

*Providers are responsible for accurately reporting services with the correct CPT and/or HCPCS codes and for appending applicable modifiers as appropriate based on medical record review. Providers should be familiar with AMA/CPT coding instructions as well as CMS code editing logic and submit claims that comply with existing guidelines.*