Reimbursement/Billing Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Maximum Units for Reimbursement/Medically Unlikely Edits (MUE)

Policy Number: RM008
Last Review: 02/01/2024

GUIDELINES:

- Paramount Reimbursement Policies have been developed to assist in administering proper payment under benefit contracts.
- Reimbursement policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.
- Paramount utilizes industry standard coding methodology and claims editing in the development of reimbursement policies. Industry standard resources include, but are not limited to, CMS National Correct Coding Initiative (NCCI), Medically Unlikely Edits (MUEs), Integrated Outpatient Code Editor (I/OCE) Clinical edits, Medical Policies, Reimbursement Policies, and Administrative/Provider Manuals. Paramount will not reimburse services determined to be Incidental, Mutually Exclusive, or Unbundled.
- All health care services, devices, and pharmaceuticals must be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes and modifiers, which most accurately represent the services rendered, unless otherwise directed by the Paramount. All billed codes must be fully supported in the member's legal medical record.
- Paramount utilizes CMS pricing algorithms where appropriate based on, National Physician Fee Schedule Relative Value File (NPFSRVF) pricing rules, Inpatient Prospective Payment Systems (MS-DRG, LTC, IPF, IRF & IPSNF) and Outpatient Prospective Payment Systems (OPPS, HHA, ASC, ESRD & OPSNF).
- Paramount liability will be determined after coordination of benefits (COB) and third-party liability (TPL) is applied to the claim. Member liability may include, but is not limited to, co-payments, deductibles, and coinsurance. Members' costs depend on member benefits.
- Paramount routinely reviews reimbursement policies. Updates are published on Paramount's website https://www.paramounthealthcare.com. The information presented in this reimbursement policy is accurate and current as of the date of publication. Paramount communicates policy updates to providers via Paramount's monthly bulletin.

SCOPE:

X Professional
X Facility – Outpatient claims. This policy does not apply to facility claims for inpatient services.

DESCRIPTION:

This policy applies to claims submitted on the CMS-1500 Claim Form or its electronic equivalent, to any Paramount Healthcare product, from network and non-network physicians, providers, and suppliers. The purpose of this policy is to define payment criteria for the maximum units of service billed on a claim, to be used in making payment decisions and administering benefits per CMS and AMA CPT coding guidelines.

Medically Unlikely Edits (MUEs) define for many Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes the expected allowable number of units of service (UOS) by the same provider, for the same beneficiary, for the same date of service. Reported units of service greater than the MUE value are unlikely to be correct (e.g., a claim for excision of more than one gallbladder or more than one pancreas). The edits are developed based on anatomic considerations, HCPCS/CPT code descriptors, CPT instructions, CMS policies, nature of service/procedure, nature of analyte, nature of equipment, and clinical judgment.

The term “units” refers to the number of times services with the same CPT or HCPCS codes are provided, per day, by the same individual physician, facility, or other qualified health care professional, (for the purpose of this policy,
the same individual physician, facility or other qualified health care professional is the same individual rendering health care services reporting the same Federal Tax Identification number).

On April 1, 2013, CMS modified the MUE program so that some MUE values would be date of service edits rather than claim line edits. Therefore, at that time, CMS introduced a new data field to the MUE edit table termed “MUE adjudication indicator” or “MAI.” MAI’s indicate CMS MUE three levels of adjudication using claim line or date of service editing.

- MUEs for HCPCS codes with a MAI of “1” indicates that the edit is a claim line MUE.
- An MAI of “2” or “3” indicates that the edit is a DOS MUE.
- MUEs for HCPCS codes with a MAI of “2” will be an absolute date of service edit. These are “per day edits based on CMS policy.” HCPCS codes with an MAI of “2” have been rigorously reviewed and vetted within CMS and obtain this MAI designation because UOS on the same DOS in excess of the MUE value would be considered impossible because it was contrary to statute, regulation, or sub-regulatory guidance.
- MUEs for HCPCS codes with an MAI of “3” are “per day edits based on clinical benchmarks”. MUEs assigned an MAI of “3” are based on criteria (e.g., nature of service, prescribing information) combined with data such that it would be possible but medically highly unlikely that higher values would represent correctly reported medically necessary services.
- If the MUE is adjudicated as a DOS MUE (MAI 2 and/or 3), all UOS on each claim line for the same date of service for the same HCPCS/CPT code are summed, and the sum is compared to the MUE value. If the summed UOS exceed the MUE value, all lines for the HCPCS/CPT code and DOS for that current claim are denied.

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

This policy is intended to ensure physicians & other qualified health care professionals and ancillary providers are reimbursed based on the code or codes which correctly describe the healthcare services provided. MUE edits are applied to claims in the pre-adjudication phase based on the values posted by CMS.

Durable Medical Equipment (DME) MUE values will be applied to ancillary providers and the Practitioner MUE values will be applied to physician/professional claims. When applicable Facility MUE edits will be applied. Billed units of service are not to exceed the MUE values defined by CMS, for a HCPCS/CPT. Billed claim lines with a unit-of-service value greater than the established MUE value for the HCPCS/CPT code will be denied payment for units above the MUE value.

MUEs codes with a MAI of “1” will continue to be adjudicated as a claim line edit. Thus, if a CPT/HCPCS code is reported on more than one line of the claim by using CPT modifiers, each line with that code is separately adjudicated against the MUE, modifier, and correct coding. If a provider bills units of service for HCPCS/CPT codes in excess of established limits, the edits prevent payment.

Paramount reserves the right to apply MUE edits outside of the CMS values when it is deemed clinically appropriate.

A denial of services due to an MUE is a coding denial, not a medical necessity denial. The presence of an Advance Beneficiary Notice (ABN) shall not shift liability to the beneficiary for UOS denied based on an MUE.

MUE values are evaluated and/or updated quarterly to reflect new, changed, and deleted codes. Because MUEs are based on current coding instructions and practices, MUEs are prospective edits applicable to the time period for which the edit is effective. A change in an MUE is not retroactive and has no bearing on prior services unless specifically updated with a retroactive effective date.

Providers shall not inconvenience members nor increase risks to members by performing services on different dates of service to avoid MUE edits.

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 06/01/2020

Date	Explanation & Changes
06/01/2020	• Reimbursement Policy created
11/01/2023	• Reimbursement Policy reviewed and updated to reflect the most recent reimbursement criteria • Changed Reimbursement Policy name from Maximum Frequency Per Day (MUE) to Maximum Units for Reimbursement/Medically Unlikely Edits (MUE)
02/01/2024	• Reimbursement/Billing Policy updated to new policy template

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

National Physician Fee Schedule Relative Value File Calendar Year XXXX, Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

NCCI Policy Manual for Medicare Services, current version, Chapter 1, General Correct Coding Policies https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and Reporting https://www.cms.gov/medicare/coding/icd10

Centers of Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 23-Fee Schedule administration and coding Requirements https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare

Center for Medicare and Medicaid Services, Medicare NCCI Medically Unlikely Edits (MUEs) https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medically-unlikely-edits

Industry Standard Review