



Table with 4 columns and 3 rows: POLICY INFORMATION. Rows include Policy Number (POL-PP- 246), Version Number (005), Policy Status (Active), Original Effective Date (7/1/2024), Revision Date (7/1/2025), and Next Revision Date (7/1/2026).

NOTICE

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Blue KC reserves the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to: https://providers.bluekc.com/ContactUs/PaymentPolicies.

Table with 6 columns: PROVIDER/ENTITY IMPACTED. Columns include PROFESSIONAL (checked), FACILITY (checked), DME (unchecked), AMBULATORY SURGERY (unchecked), LAB (unchecked), and OTHER (unchecked).

Table with 7 columns: LINES OF BUSINESS IMPACTED. Columns include COMMERCIAL (checked), BLUE MEDICARE ADVANTAGE (checked), ACA QHP1 (checked), SMALL GROUP ACA (checked), JAA2 (checked), FEP3 (checked), and DENTAL (unchecked).

1 ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family 2 JAA: Joint Administrative Account 3 FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
Centers for Medicare and Medicaid
American Medical Association
National Correct Coding Initiative
Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
Affordable Care Act Provider Hotline 866-859-3822
Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.



Description/Application

A medically unlikely edit (MUE) for a HCPCS/CPT code is the maximum number of units of service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/supplier for the same beneficiary on the same date of service. Medically Unlikely Edits (MUEs) prevent payment for an inappropriate number/quantity of the same service on a single day.

Policy

MUE's are published with an adjudication indicator. The MUE adjudication indicator (MAI) indicates the type of MUE and its basis. The MAI assigned to HCPCS/CPT codes will determine how the claim will process and/or deny.

MAI of 1

MUE's for CPT/HCPCS codes with a MAI of "1" will continue to be adjudicated as a claim line edit.

Blue KC adjudicates MUEs against each line of a claim rather than the entire claim. 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.

CPT modifiers such as 59 X-[EPSU], -76, -77, and anatomic modifiers (e.g., RT, LT, FA-F9, TA-T9), -91, will accomplish this purpose. If a provider bills units of service for HCPCS/CPT codes in excess of established limits, the edits prevent payment. Blue KC denies at the line level rather than the claim level for both Physician and Facility claims.

MAI of 2

MUEs for HCPCS codes with a MAI of "2" will be an absolute date of service edit. These are "per day edits based on policy."

HCPCS codes with an MAI of "2" have been rigorously reviewed and vetted within CMS and obtain this MAI designation because units of service (UOS) on the same date of service (DOS) in excess of the MUE value would be considered impossible because it was contrary to statute, regulation, or sub regulatory guidance.

This sub regulatory guidance includes a clear correct coding policy that is binding on both providers and CMS claims processing contractors.

Modifiers such as 59 X-[EPSU], -76, -77, and anatomic modifiers (e.g., RT, LT, FA-F9, TA-T9), -91 will not override a denial for MUE's with a MAI of 2 as they are an absolute date of service edit.

MAI of 3

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.

For MUE's with a MAI of 3, Blue KC will reimburse up to the allowed amount found on the NCCI Medically Unlikely Edits table. Units billed in excess of the allowed amount will be denied.

If the provider feels the additional units submitted were medically necessary, supporting documentation may be sent for review.



Documentation must provide

- Support of additional units as reasonable and necessary
- details supporting the additional units reported
- the rationale and medical reasonableness for performing additional units

If changes appear in the medical record following the payment determination based on medical review, only the original record will be reviewed in determining the payment of services billed.

Coding

To view the National Correct Coding Initiative Medically Unlikely Edits table, go here,

<https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-medically-unlikely-edits>

References and Resources

CMS National Correct Coding Initiative
Blue KC Provider Reference Guide

Related Documents

Payment Policy POL-PP-226 National Correct Coding Initiative (NCCI)

Revision History

Date	Summary of Revisions
7/1/2024	New Policy
7/1/2025	Annual review, there were no changes or updates made to the policy