

Medically Unlikely Edits (MUE)**Date of origin: April 2026****Review dates: None yet recorded****DEFINITION**

Medically unlikely edits (MUEs) were established by CMS to lower the Medicare FFS paid claims error rate. MUEs are the maximum unit of service edits that are applied to claims reported by the same provider or supplier for the same beneficiary on the same date of service.

Priority Health adheres to CMS guidelines, and all claims are subject to applicable MUE limits.

MUE is processed as either claim line or date of service (DOS) edits.

A MUE Adjudication Indicator (MAI) can be found in the MUE files on the CMS NCCI website and display the following:

- 1 – claim line edit
- 2 – DOS edit based on policy and considered absolute date of service
- 3 – DOS edit based on criteria such as nature of service or prescribing information

MEDICAL POLICY

N/A

POLICY SPECIFIC INFORMATION

Most MUE values are established to ensure that claim line denials occur only infrequently for providers or suppliers. MUEs are NOT utilization guidelines; providers must only report services or items that are medically reasonable and necessary.

Under claim line MUE edits, reported units of service are measured against the MUE value, and any line exceeding the MUE is denied in full.

DOS MUE edits sum the units of service for the same CPT/HCPCS code on the same date of service; when the total exceeds the MUE value, all units are denied

MAI of 2 represents a fixed date of service edit. Units of service exceeding the MUE are prohibited under statute, regulation, or sub-regulatory guidance.

MAI of 3 designated per-day edits grounded in clinical benchmarks, and units exceeding the MUE are considered highly medically unlikely based on the nature of the service and prescribing information.

Careful review of code descriptors is essential. When evaluating code descriptions, consider the following:

- Anatomical considerations
- Descriptors that include the term “initial”
- Descriptors specifying a defined timeframe such as “per day,” “per week,” or “per month”
- Descriptors written in the plural form of the procedure (e.g., “biopsies”)

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information [in our Provider Manual](#).

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

For reconsiderations of denials associated with an MAI of 1 or 3, submitted documentation must substantiate the following requirements:

- Correct CPT/HCPCS code selection and usage
- Accurate reporting and calculation of units of service
- Medical reasonableness and necessity of all services billed
- An explanation for any variance from established national utilization or practice patterns

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

- Anatomical modifiers
- Modifier 50 - Bilateral Procedure. Submit a single claim line with the appropriate code and modifier 50 appended; report total units as "1." This modifier is not appropriate when the code description includes "bilateral."
- Modifier 76 - Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
- Modifier 77 - Repeat Procedure by Another Physician or Other Qualified Health Care Professional
- Modifier 91 - Repeat Clinical Diagnostic Laboratory Test
- 59, XE, XS, XU – Distinct Services
- Modifier LD – Left anterior descending coronary artery
- Modifier LM – Left main coronary artery
- Modifier RC – Right coronary artery
- Modifier RI – Ramus intermedius coronary artery

FAQ

Resources

<https://www.cms.gov/files/document/revised-modification-medically-unlikely-edit-mue-program-mm8853.pdf>

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

[Chapter 1 General Correct Coding Policies for Medicare National Correct Coding Policy Manual Section V. Medically Unlikely Edits \(MUEs\)](#)

Related policies

[Billing policy No. 022 General Coding](#)

[Anatomical Modifiers](#)

[Modifiers 76 and 77, repeated procedure\(s\)](#)

[Modifiers 59, XE, XS, XP & XU, separate or distinct services](#)

Related denial language

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste, and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available [in our Provider Manual](#).

CHANGE / REVIEW HISTORY

Date	Revisions made
April 2026	New policy