Reimbursement Policy

Title: Medically Unlikely Edits (MUE)	
Policy Number: RP07	**Applies to:** ☒ Commercial
Effective Date: 3/15/2026	☒ Level Funded
Last Updated:	☒ Medicare Advantage ☒ Medicaid

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc., is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines, including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities unless a specific exception is stated in the policy.

If proper coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

Medically Unlikely Edits (MUEs): Claim edits developed by CMS to prevent payment for services that are very unlikely to be correct, such as claims that report an excessive number of units for a procedure on the same patient on the same day

MAI (MUE Adjudication Indicator): CMS assigns each MUE a type (1, 2, or 3) indicating how strictly the edit is applied and whether medical record review is allowed

NCCI: National Correct Coding Initiative: The CMS program that establishes MUEs and other coding policies to promote proper coding methods and control improper coding

Policy

Quartz follows CMS National Correct Coding Initiative (NCCI) and ForwardHealth standards for MUEs. MUEs help ensure that billing reflects medically reasonable and appropriate services.

There are three categories of MUE adjudication indicators:

- MAI 1 – Claim Line Edit (May be overridden): These edits are based on clinical benchmarks and can be overridden with proper documentation. Appeals are considered with supporting evidence.
- MAI 2 – Absolute Date of Service Limit (Cannot be overridden): These edits are hard limits set by CMS based on anatomical or clinical realities. No number of modifiers or documentation will result in payment above the limit.
- MAI 3 – Date of Service Edit (May be overridden): These edits are based on clinical scenarios where higher units may be applicable. Additional units may be payable if sufficiently documented. Quartz will review these claims when appealed with supporting documentation.

Quartz applies MUEs across all professional, outpatient facility, and DME claims. When submitting claims, Quartz expects that units equal to or below the MUE be billed on one line, and all units exceeding the MUE should be billed on a second line. Charges associated with the units exceeding the MUE billed on a UB claim form should be placed in the appropriate non-covered charges field. Claim lines that exceed the MUE limit will be denied, however, these may be appealed with supporting documentation if the MAI allows.

For Commercial, including Level Funded and Medicare Advantage lines of business only:

When submitting claims for DME and supplies intended as a multi-day supply, these items must be date-spanned to reflect the full duration of use. Instead of submitting single-day claim lines, providers shall indicate the full supply period by date spanning the claim line.

For example, if a patient requires a supply for three months, the billing should reflect the entire coverage period.

- Example: If the supply period begins on February 1, 2026, and extends through April 30, 2026, the claim should be submitted with the date range of 2/1/26-4/30/26.

Related Policies

Drug Waste

Resources

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

ForwardHealth, National Correct Coding Initiative MUE Information
https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=130&s=4&c=24&nt=National%20Correct%20Coding%20Initiative&adv=Y

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

Document History

2/6/26	Document created	Payment Integrity Department
