Tips For Successfully Appealing Medically Unlikely Edit (MUE) Claim Denials

CASP
The Council of Autism Service Providers

What is this resource?

For Applied Behavior Analysis (ABA) CPT code 97151, most payers deny claims that exceed 2 hours, deeming them medically unnecessary despite evidence to the contrary. CASP developed this toolkit to help members successfully appeal MUE claim denials.

What is an MUE?

A Medically Unlikely Edit (MUE) establishes the maximum units of service that are typically reported for a CPT code. While published MUEs are meant to provide guidance, payers often use them to enforce limits for daily service hours. In many cases, insurance companies' adjudication systems automatically deny claims that exceed the published MUE.

MUEs are not intended to restrict medically necessary treatment or override the clinical judgement and recommendations of healthcare providers. Qualified Healthcare Professionals decide the duration and number of assessment sessions that are medically necessary for a specific client. When they determine it's clinically appropriate to provide more than two hours per day of assessment services, the provider should bill accordingly.

All ABA CPT codes have an adjudication indicator of three. That means all claims that meet the criteria for medical necessity are expected to be paid, even when they exceed the MUE. Preauthorization alone—typically required for ABA—establishes medical necessity.

Why have we created this resource?

As providers, it's incumbent on us to provide medically necessary services in the most effective, appropriate way. We encourage all CASP members to bill for all the medically necessary services they provide, including billing beyond MUEs. While your organization may see an increase in MUE denials, this will establish precedents for how services are actually, effectively rendered.

Our ultimate goal is to align CMS guidance and payer policies with ABA best practices. Keep in mind: MUEs are determined by what's reasonable and customary. This standard is established through actual claims data. If we're all underbilling in deference to an MUE, then we're *undermining* efforts to ensure guidance and policy reflect ABA best practices. Failing to appeal MUE denials undermines efforts, also. Payers will continue current practices in the absence of claims data that accurately reflects services provided beyond an MUE.

How do we appeal MUE denials?

Follow these simple steps.

Before a denial

- Are you billing services under 97151 or 97152 on the same day that you're billing services under other codes? Submit 97151 and 97152 separately from other ABA codes. Make one claim for assessment codes and another for treatment codes. That way, you don't receive a blanket denial for all services rendered.
- If an MUE was exceeded, include in your clinical notes an explanation of medical necessity. For Example:
    - 97151 visit exceeded two hours.
        - Client status indicated that assessment length was necessary to develop sufficient social reciprocity, motivation, and responding.
        - Client profile complexity required more than two hours of assessment per day.
        - Other: (allows provider to write in answer)

Appealing after a denial

Please note that this process/letter template can be used for all ABA codes. Simply update the code as needed.

- Input relevant denial info into CASP letter template.
- Include guidance documents to support appeal.
    - Guidance from ABA Coding Coalition.
    - Guidance from CMS.
    - NCCI Letter.
- We recommend compiling your appeal in this order.
    - Letter.
    - Three guidance documents.
    - Pre-authorizations and requests (optional).
    - Clinical notes (Optional).
    - Treatment plan (Optional).
- Please track your appeals by completing this survey. We hope that by sharing experiences and de-identified data with other CASP members, we will achieve better outcomes.

YOUR COMPANY NAME
YOUR COMPANY ADDRESS

INSURANCE COMPANY NAME
INSURANCE COMPANY ADDRESS

Patient Name:
Patient DOB:
Patient Insurance ID:
Date of Service:
CPT Codes:
Claim ID Number:

Appeal Information:

On date of service XX/XX/XXXX, CPT Code 97151 was denied. XX units were billed and XX are unpaid. We are authorized for—and have not exceed—XX units of CPT Code 97151 under authorization number XXXXXXX.

The claim was denied for exceeding the two-hour daily Medically Unlikely Edit (MUE) limit for CPT code 97151. However, it's clinically appropriate—and consistent with standard Applied Behavior Analysis (ABA) practice—to provide more than two hours of this service per day.

This service was authorized as requested [or the insurance company determined authorization was not required], and the approved hours for 97151 were determined to be medically necessary. The clinician used their professional judgment to allocate these hours based on the patient's needs. Therefore, the insurer should cover all hours provided within the *total* approved/allowed amount, regardless of the number of hours rendered *per day*.

MUEs are not intended to restrict medically necessary treatment or override the clinical judgement and recommendations of healthcare providers. All ABA CPT codes have an adjudication indicator of three. This means that if medical necessity is met—as is the case here—the claims are expected to be paid even if the MUE has been exceeded. Typically, prior authorization for applied behavior analysis (ABA) is required. When services are preauthorized, medical necessity has been established.

Denying claims based on exceeding MUEs, especially when they are preauthorized, contradicts both CMS guidelines and MHPAEA. It is standard practice in the field of ABA for 97151 to be delivered for more than two hours per day. The Council of Autism Service Providers' (CASP) ABA Practice Guidelines—the generally accepted standards of care in this field—specifically state that "due to the comprehensive nature of the assessment process, it may require 20 hours or more to complete the evaluation. The assessment should be conducted at regular intervals (e.g., on an annual or semiannual basis). There should be no restriction on the number of assessment hours on any given day, though long assessments (e.g., 20 hours) should be spread out across multiple days."[1]

The Medicare limit for this code is eight units, or two hours, per day. The MUE differs from general practice, where assessment sessions often take place across a series of sessions within a single day or

across multiple dates of service. CPT 97151 also includes non-face-to-face activities—such as records review, data analysis, interpretation of assessments and evaluations, and program development—making it standard practice to use more than two hours per day for activities within this code.

MHPAEA prohibits quantitative treatment limits (such as visit limits) on mental health benefits if not applied to substantially all coverage for medical/surgical benefits in the same statutory classification (i.e., outpatient). "Substantially all" is defined by MHPAEA as two-thirds of Med/Surgical procedures (§ 2590.712 (b) (4). (A QTL must be no more restrictive than the predominant QTL applied to substantially all medical/surgical coverage in the same statutory classification.) 29 C.F.R. § 2590.712(c)(2); 45 C.F.R. §146.136(c)(2).

This insurance company is enforcing an MUE that does not align with how these services are and should be provided. As stated by the ABA Coding Coalition, the Medicaid MUEs list most accurately reflects how ABA services are provided, considering they are *covered* by Medicaid and not Medicare.[2] Medicaid lists the MUE on 97151 as 8 hours, or 32 units, per day. The 97151 Medicare MUE of two hours per day is unnecessarily restrictive, as this type of service is typically provided for more than two hours per day.

By restricting assessment to two hours per day—rather than the eight hours per day outlined by the Medicaid MUE—the insurance company has imposed a quantitative treatment limit that violates MHPAEA, contradicts the generally accepted standards of care, increases financial burdens on the family through increased copays, and delays access to treatment by imposing unnecessary administrative requirements. Please note that generally accepted standards of care must be written by a non-profit trade association that is not associated with the health plan.

We request that you overturn this denial and pay the claim in full, as the two-hour daily MUE is not an appropriate cap for this service. Providing more than two hours per day is medically necessary and aligns with generally accepted standards of care for this treatment, meeting the requirements outlined by CMS for CPT codes with MUE Adjudication Indicator (MAI) 3.

To support our appeal we have attached:

- Guidance from the ABA Coding Coalition.
- Guidance from CMS.
- NCCI Letter.
- Clinical notes.
- Treatment plan. (Optional)

Sincerely,

[Your Name]

[1] Council of Autism Service Providers [CASP] (2024). Applied behavior analysis practice guidelines for the treatment of Autism Spectrum Disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers [Clinical practice guidelines]. https://www.casproviders.org/asd-guidelines

[2] ABA Coding Coalition. December 2020 Update #1. https://abacodes.org/wp-content/uploads/2020/12/FINAL-Medicaid-MUE-letter-to-payers-11.17.20.pdf.