How to Write an Effective Appeal
Provider Version

EIMBURSEMENT™
At LDR, we understand the changing healthcare environment and how that impacts reimbursement. As the U.S. healthcare system becomes increasingly complex, it is important to have resources and support in the effort to navigate coverage and payment decisions. The following is a step-by-step guide on the elements of an effective appeal. Initial steps that providers can take to positively affect reimbursement outcomes include:

- **Provide continuing education in revenue cycle management to staff.**
- **Adequately follow up with insurers.**
- **Stay involved through advocacy and communication with payers.**

**The appeals process** is the mechanism for health plans to review medical necessity denials in accordance with their Medical Policy Guidelines. Whenever a Prior Authorization or claim for services is denied by an insurance company, it is critical to appeal the decision. It can be time consuming to appeal, but we encourage persistence. The appeal requires the plan to review the proposed procedure and can identify the need to modify the coverage policy.

To present an effective appeal, remember these four basic steps:

1. **Review and understand the health plan’s reason for denial.**
2. **Write an appeal letter that clearly addresses the points raised by the health plan’s denial letter.**
3. **Include any attachments that provide new information and support the points argued in the appeal.**
4. **Submit the appeal on time.**

Additional actions to consider:

- **Discuss with the patient their right to contact the payer.** The patient is the policy holder and has the most influence.
- **Encourage the patient to work with their Human Resources Department if their plan is employer-based.** Whether an independent plan or self-insured (funded), the HR department can be very helpful when it comes to working with the plan.
- **Contact your Provider Relations Department.** While often this office may handle contracting issues only, they may also offer support for resolving disputes such as those that relate to Medical Policy Guidelines.
Step one: Review reason for denial

Most denial letters follow a similar pattern and are filled with legally required language. Below, find a description of the language that might be found in a letter of denial.

Identifying information
This information typically includes the patient’s name, the service requested, a number used by the health plan to identify the patient or case, the provider, and dates of service, CPT codes, or description of the requested procedure/treatment.

Reason for denial
The letter may use the terms, ‘Not Medically Necessary’ or ‘Investigational/Experimental’, which are not typically the reason for denial. Look further for something that specifically applies to this case. The reason is usually only a paragraph or two long and can be identified by a reference to the patient’s specific condition, health records, and the health plan’s comparison to their medical criteria or policy.

Hint: The reason for denial is usually plugged into a template and may sound different than the rest of the letter. It explains the questions or hesitations the health plan has about the case that will need to be answered in the appeal.

Right to request information
Be certain to request a copy of the criteria that was used to make the decision. Often, the criteria is based on outdated or unrelated information.

Description of the appeals process
This section provides a long explanation on the next level of rights.
Step two: Write an appeal letter

An appeal letter should have an introduction that clearly identifies the letter as an appeal to a specific denial, a body that supports the reason, and an ending that tells the plan what action or outcome is expected. LDR has suggested templates that may prove useful in this regard.

Obtain an ‘Authorization to Appeal’ from the patient or insured so that an appeal may be submitted on behalf of the patient. Some plans provide a special form for this.

Include the:
- Name of the patient
- Name of the insured
- Policy number
- Date of prior authorization or claim which was denied
- Name of service denied with the CPT code(s)

Gather the relevant paperwork needed to write the letter.
- Denial letter
- EOBs (Explanations of Benefits)
- Health plan handbooks and contracts
- Receipts and bills
- Supporting published materials that may be utilized to support the procedure/product
- The health plan's medical policy that applies to the issue

Hint: In reviewing the denial letter, consider the following questions. Did the plan miss something important? Did the plan review all the information provided? Was the recommended treatment not covered by the plan?

The issues raised by the health plan must be addressed in the letter.
**State the patient’s case**
Support the treatment description with medical records. Leaving out important information may delay a response or even result in another denial.

- **Detail the patient’s medical history before and after the start of the disease.**
  - Describe how the disease affects the patient’s daily life. Include details such as how the disease affects the patient’s ability to stand, sit or walk for a long period, lift or carry weight, or sleep normally.
  - If the health plan details treatments that must be completed prior to surgery, ensure this has been done. Provide the details and describe the outcome.
  - Describe what will happen if the patient does not have the procedure.
- **Explain why the patient is a candidate for this treatment** as opposed to a treatment the plan deems covered under the Medical Policy Guidelines.
- **Discuss any experience with same or similar treatments with other patients.** Expound upon the physician’s personal experience in the field and with the specific treatment, (e.g., how many cases performed or whether treatment is supported by specialty societies).
- **If possible, refer to the exact page of the member handbook, contract, or the health plan’s medical policy** that applies to the patient.

Many times treatment that is costly in the short-term may cost the plan less over time. If this is the case, also outline this information in the appeal.

**At the end of the letter, in one brief sentence, tell the health plan again what action is expected.** Remember, it is important to demonstrate why the patient needs the medical service.

**Note:** Many health plans will allow attendance or participation in the Level II appeal hearing either in person or via teleconference. Consider doing this as an effective way to present the appeal.
Step three: Include supporting attachments

When writing an appeal letter, remember the health plan uses evidence-based medical policies and/or clinical guidelines to make decisions. It is important to use similar information to provide a reason why the plan should cover the treatment.

**Hint:** The health plan is not obligated to pay for all treatments or procedures that a medical provider recommends. Plans will only pay for treatments as outlined in the insurance contract/benefit booklet. To provide the health plan with documentation that supports the appeal letter, attach well-researched medical information.

Here are some types of information that may be beneficial in the appeal:

- **Medical journal articles** – Include articles about specific conditions or treatments that support the procedure. These articles must be peer-reviewed scientific studies that meet nationally recognized standards. LDR has a library of peer-reviewed documentation available to support the use of our products.
- **Treatment studies or clinical trials** – Include studies that measure results for the type of treatment that is sought. Information regarding clinical trials and studies for our products is available directly from LDR or from www.fda.gov.
- **Position statements** – Include position statements, consensus statements, or treatment guidelines developed by government agencies, specific medical specialty organizations, and other specialty groups to support the appeal. Ask the health plan for a copy of the materials they relied upon in making their decision.
- **Medical reference books** – Include information from a standard medical reference book on the spine.
- **State and federal laws** – Include any state and federal laws that may require the health plan to provide certain services.
Step four: Submit the appeal on time

Make sure the deadline has been met. The health plan must receive an appeal letter before the filing deadline. If the appeal falls outside of the timeframe, the right to appeal has been lost.

Send appeal by certified mail, return receipt requested. If submitting electronically or by fax, be sure to keep a copy with the submission date. Always send copies of all the paperwork and keep originals in the patient’s chart.

What if the claim is still denied? If the plan denies the initial appeal, there are additional levels of appeal. A request can be made to present the appeal to a new group of external professionals, who are not employed by the plan.

Finally, if the procedure is again denied and the health plan’s internal and external appeals process has been exhausted, there still may be entitlement to a review through the State Department of Insurance.

Hint: The Affordable Care Act provides for additional appeal rights. For further information visit www.hhs.gov/healthcare/rights/appeal/appealing-health-plan-decisions.html.