Appeals Letter Templates

Contents

Instructions

These appeals letters were designed to make it easier for you to respond appropriately to claims denials. Once you customize the letters, you can print them when you need them, or print several of each to keep in a folder at the front desk.

The information that requires your input is highlighted in yellow and offset by carets (<>). To customize the letters, replace the highlighted sections with the appropriate information and save (be sure you *Save As* with the appropriate title such as '97140AppealAnthem_JDoe_2018')

Before sending the letter, be sure you:

- Delete the title in the Header (it is only to make it easier for you to select the correct template) and insert your letterhead
- Verify the address for the payer
- Include any necessary attachments
- Complete all areas that require input and delete all of the carets
- Sign the letter

<OFFICE LETTER HEAD>

<Date>

<Business Name>
<Business Address>

Re: Denial for Services Rendered to <Patient Name> on <Date>
Group #
Policy #
Claim #

To Whom It May Concern:

I reviewed your correspondence regarding the above named patient's treatment. The <select: letter/EOB> explains that payment for CPT® code 97140, *manual therapy techniques*, was not covered because it is considered a mutually exclusive procedure with CPT code <select: 98940, 98941, 98942> *chiropractic manipulative treatment* (*CMT*).

The American Chiropractic Association (ACA), the largest professional association representing doctors of chiropractic (DCs) in the country, currently has two members that represent the field of chiropractic on advisory committees established by the American Medical Association (AMA) for the purpose of developing, valuing, and maintaining CPT codes used to report chiropractic services. Both members are intimately involved and regularly consulted when the definition or intent of a code is in question. Based on their knowledge of the development and valuation process for CPT codes 97140 and <select: 98940, 98941, 98942>, it is their understanding that CPT code 97140 is not a mutually exclusive procedure when provided to a different body region separate from the CMT procedure described by CPT code<select: 98940, 98941, 98942>. When these procedures are billed together the modifier "59" is used to indicate independent procedures were performed.

"Manual therapy techniques consist of, but are not limited to, connective tissue massage, joint mobilization and manipulation, manual traction, passive range of motion, soft tissue mobilization and manipulation, and therapeutic massage." As the code descriptor states, 'manual' providers use their hands to administer these techniques. Therefore, code 97140 describes 'hands-on' therapy techniques.

Typically, the goals of manual therapy are to modulate pain, increase joint range of motion, and reduce or eliminate soft tissue swelling, inflammation, or restriction. These techniques also induce relaxation and improve contractile and noncontractile tissue extensibility.

Under certain circumstances, it may be appropriate to additionally report CMT/OMT codes in addition to code 97140. For example, a patient has severe injuries from an auto accident with a neck injury that contraindicates CMT in the neck region. Therefore, the provider performs manual therapy techniques as described by code 97140 to the neck region and CMT to the lumbar region. As separate body regions are addressed, it would be appropriate in this instance to report both codes 97140 and 98940. In this example, the modifier -59 should be appended to indicate that a distinct procedural service was provided."[1] [1]

Based on this information, I have attached a copy of my clinical records for the date(s) of service in question. They clearly indicate that these services were provided to separate body regions. The documentation also supports that these services were necessary because <insert statement of medical necessity>.

[1] CPT Assistant, Volume 9, Issue 3, March 1999

Certain coding edits imply that CMT and CPT code 97140 can never be performed on the same date of service, even if performed on separate body regions. Please note that this is not correct CPT coding policy and has been specifically re-clarified by the AMA. For a copy of AMA CPT's position on this topic, please contact the ACA at memberinfo@acatoday.org.

If you require additional information specific to this patient or claims appeal, please feel free to contact me at <insert your contact information>, otherwise please forward payment for the <denied/reduced> services within 30 days.

Sincerely,

<Doctors Name>

Enc: (Clinical records for (select: this/these date(s) of service – Insert patient's name)
Cc: American Chiropractic Association

E/M with CMT Appeal

<OFFICE LETTER HEAD>

<Date>

<Business Name>
<Business Address>

Re: Denial for Services Rendered to <Patient Name> on <Date>
Group #
Policy #
Claim #

To Whom It May Concern:

Thank you for your <select: letter/EOB> regarding the above-referenced patient for services rendered on <insert dates of service>. I appreciate the time you took to communicate with me, but disagree and object to your determination that the evaluation and management CPT® code (E/M) is a mutually exclusive procedure when billed with a chiropractic manipulative treatment (CMT) CPT code <98940-98942>.

As outlined in the American Medical Association's (AMA) Current Procedural Terminology (CPT), there are instances when it is appropriate to bill a CMT code with an E/M code on the same date of service.

The physician work component of the CMT codes includes a brief pre-manipulation patient assessment. Additional evaluation and management services may be reported separately using the modifier –25 if, and only if, the patient's condition requires a significant, separately identifiable E/M service, above and beyond the usual pre-service and post-service work associated with the procedure.

The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. On any given visit, if the patient presents more than one specific area of complaint that necessitates separate and distinct clinical evaluations, use of an E/M service code should be the service that most accurately reflects the cumulative level of all services provided during the visit. As such, different diagnoses are not required when reporting the E/M service on the same day.

Some specific examples of when it is appropriate to bill for both a CMT and E/M code on the same date of service are:

- New patient visits
- Established patients with new conditions, new injuries, aggravations, or exacerbations
- Periodic re-evaluations to assess whether a treatment change is needed

In these cases, the reason the E/M service was billed in addition to the CMT was <insert statement of medical necessity>. I have attached appropriate documentation, which supports the need for the E/M service on this date.

The American Chiropractic Association (ACA) recommends the use of the E/M documentation requirements that were developed by the AMA and the Centers for Medicare and Medicaid Services (CMS) for use by all physicians. In light of the above, please reconsider and accurately reprocess the above patient's claim within 30 days.

Sincerely,

<Doctor's Name>

Enc: <Clinical record for [select: this/these] date(s) of service – Insert patient's name>
CC:

ERISA Appeal Letter

<OFFICE LETTER HEAD>

<Office name or Doctor's Name>
<Business Address>

<Date>

<Recipient's Name>
<Business Address>

Via Certified Mail, Return Receipt Requested

RE: <Patient Name>
<ID/Policy #>
<Plan Name>

Dear Plan Administrator:

Please be advised that I am acting as the authorized representative for <patent's name> and I am writing to appeal <name of health plan>'s decision to deny payment for <name of service, procedure OR treatment> for <patient's name>. The <name of health plan> has denied coverage for <name of service, procedure OR treatment>, as <insert reason for denial>. Be advised the <name of service, procedure OR treatment sought> is medically necessary to <treat OR diagnose> the patient's condition and is covered by <patient's name>'s health plan. Enclosed please find a copy of the patient's signed Authorization Form, naming me to act as the patient's representative in this appeal.

Requested resolution:

- ❑ Reimbursement of previously denied claim(s) for date(s) of service: _____
- ❑ Approval for coverage of these previously denied benefits: _____

If request is not fulfilled, Pursuant to 29 CFR 2560.503-1(g)(v)(A); 503-1(h)(2)(iii); and 503-1(h)(3)(iii) -(v), please provide the following information to me upon receipt of this letter:

1) A copy of the specific rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination
2) A copy of all documents, records, and other information relevant to my claim for <describe what the claim is for>
3) The name and curriculum vitae of all health care professionals with whom <payer/company> consulted prior to the adverse benefit determination. This information should also include reference to the health care professionals' experience and training in <the particular specialty under which your claim is being made>, including a list of all peer review articles authored by these professionals
4) The identification of all medical or vocational experts whose advice was obtained on behalf of the plan in connection with my adverse benefit determination without regard to whether the advice was relied upon in making the determination.

Pursuant to 29 CFR 2560.503-1(m)(8), a document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information:

i) Was relied upon in making the benefit determination
ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination
iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or
iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Should you have any questions, feel free to contact me at <phone number or email>. Thank you for your review and action on this appeal.

Sincerely Yours,

<Doctor's Name>

CC: <Insert patient's name and address>)

ERISA Request for SPD

<OFFICE LETTER HEAD>

<Office name or Doctor's Name>
<Business Address>

<Date>

<Recipient's Name>
<Business Address>

RE: <Patient Name>
<ID/Policy #>
<Plan Name>

Dear Plan Administrator:

Pursuant to 29 U.S.C.A. §1024(b)(4), please send me a copy of the Summary Plan Description (SPD) (and any amendments thereto since the inception of the Plan), for the above-referenced Plan. Please be sure to include the following:

- Summary Plan Description
- Form 5500
- Plan Appeal Procedures
- Explanation of Chiropractic Benefits

Enclosed please find a signed copy of the patient Authorization Form authorizing me to act as the patient's representative.

This request follows U.S. Department of Labor guidelines that indicate:

> *"A plan's claims procedures may not preclude an authorized representative (including a health care provider) from acting on behalf of a Claimant and further provides that a plan may establish reasonable procedures for verifying that an individual has been authorized to act on behalf of a Claimant."*

Please note, Section 502(a)(1)(A) of ERISA indicates the Plan Administrator has thirty (30) days to provide the SPD to the enrollee/beneficiary. The Plan Administrator may be held liable for up to $110.00 per day for each day he/she fails to provide the SPD to the enrollee/beneficiary. As the Plan Administrator of the subject's medical plan, you also have a fiduciary duty to ensure that these documents are sent to me.

I await your prompt reply. Thank you for your assistance in this matter.

Sincerely Yours,

<Doctor's Name>

Enc:
CC: <Insert patient's name and address>)

Maintenance Denial Appeal

<OFFICE LETTER HEAD>

<Date>

<Business Name>
<Business Address>

Re: Re: Denial for Services Rendered to <Patient Name> on <Date>
Group #
Policy #
Claim #

To Whom It May Concern:

Thank you for your <select: letter/EOB> regarding the above-referenced patient for services on <date>.

I appreciate your communication but respectfully disagree and object to your position denying <insert code> based on your definition of maintenance/supportive care.

The American Chiropractic Association differentiates between these two types of care and defines them as stated below. Based on these definitions, it is clear that supportive care is being rendered in this instance.

Supportive Care - Long-term treatment/care that is therapeutically necessary. This is treatment for patients who have reached maximum therapeutic benefit, but who fail to sustain benefit and progressively deteriorate when there are periodic trials of treatment withdrawal. Supportive care follows appropriate application of active and passive care including rehabilitation and/or lifestyle modifications. Supportive care is appropriate when alternative care options, including home-based self-care or referral have been considered and/or attempted. Supportive care may be inappropriate when it interferes with other appropriate primary care, or when risk of supportive care outweighs its benefit (e.g., physician/treatment dependence, somatization, illness behavior or secondary gain[1,2,3,4]).)

Preventative / Maintenance Care - Elective health care that is typically long-term, by definition not therapeutically necessary but provided at preferably regular intervals to prevent disease, prolong life, promote health, and enhance the quality of life. This care may be provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration; or it may be initiated with patients without symptoms in order to promote health and to prevent future problems. This care may incorporate screening/evaluation procedures designed to identify developing risks or problems that may pertain to the patient's health status, and give care/advice for these. Preventative/maintenance care is provided to optimize a patient's health[1,2,3,4]. (Ratified by the House of Delegate, June 1998)

1. Chapman-Smith D. Scope of Practice. The Chiropractic Profession. NCMIC. Toronto, Canada; Harmony Printing Limited, 2000; 94-5.
2. Chapman-Smith D. Long-Term Care-Justification and Reimbursement. The Chiropractic Report. Jan 1994; 8(1); 2.
3. Haldeman S, et al, eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters. Gaithersburg, Maryland; Aspen Publishers; 1993; Chapter 8; 115-127.
4. Henderson DJ, et al, eds. Clinical Guidelines for Chiropractic Practice in Canada. Supplement to JCCA; 1994; Glossary; 193-4.

To combine or misinterpret these definitions and base your denial on an inaccurate description of care could be deceitful and harmful to the patients you insure. I hope these nationally recognized definitions allow you to reassess your own definitions of care and provide payment as soon as possible.

Sincerely,

<Doctor's Name>

Enc: Clinical record for<this/these> date(s) of service – Insert patient's name>
CC: State Chiropractic Association/Society

Medical Necessity Comprehensive Appeal

<OFFICE LETTER HEAD>

<Date>

<Business Name>
<Business Address>

Re: Denial for Services Rendered to <Patient Name> on <Date>
Group #
Policy #
Claim #

To Whom It May Concern:

I respectfully disagree with your decision to deny the services rendered and billed for the above-named patient as not medically necessary. My clinical documentation is clear and demonstrates medical necessity as I understand it from:

<Explain, citing of the source for your understanding of why the care is medically necessary…what are you basing your argument on: your carrier's medical review policy; CCGPP and/or other chiropractic guidelines; protocols taught in accredited chiropractic colleges; scope of practice within this state, etc.>

<Share the story of the patient's experience in your office. Often, medical necessity denials occur because the carrier hasn't segmented the various episodes of care but rather has run all of the care together. You can often tell if this is the case because the denial came after another episode of care began. If the denied care is the only active episode of care, skip the next paragraph)

This patient originally presented to our office on <date previous episode of care started>, was given a diagnosis of <fill in> and underwent an active treatment plan for this episode of care. This patient reached maximum improvement and was discharged from active care for this diagnosis on <date>.

Note: If you must explain multiple episodes of care, complete as many paragraphs as necessary (patterned after the one above) to help the reader understand the patient's story.

This patient then experienced <Fill in example: new injury, exacerbation, relapse> that required an additional episode of intensive treatment and care after being diagnosed with <fill in>. My determination for care is based on the following objective findings: <list the findings>. The prognostic factors (complicating factors) that have affected the patient's rate of improvement for this episode of care are: <list>. The patient <was or is> scheduled to be discharged from the episode of care on or around <date>.

I have enclosed a copy of the patient's history, examination, active treatment plan, and daily notes as evidence of medical necessity. The notes indicate the patient's improved function through this episode of care. I have acted in good faith to provide this care and to provide you with this information; in turn I request that you fulfill your fiduciary responsibility to this patient to provide reasonable, fair, and necessary care under the terms of the policy.

Your personal attention in reviewing this situation is appreciated. Please consider this information and provide me with your response within the next 30 days.

Sincerely,

<Doctor's Name>

Enc:
CC:

Medical Necessity General Appeal

<OFFICE LETTER HEAD>

<Date>

<Business Name>
<Business Address>

Re: Denial for Services Rendered to <Patient Name> on <Date>
Group #
Policy #
Claim #

To Whom It May Concern:

I respectfully disagree with your decision to deny the Chiropractic Manipulative Treatment for the above-named patient as not medically necessary. My clinical documentation is clear and demonstrates medical necessity. It is consistent with patient care protocols taught in accredited chiropractic colleges and clearly falls under the scope of practice within this state.

This patient experienced <*Fill in: e.g.,* new injury, exacerbation, relapse> that required more intensive treatment and care. My determination for care is based on the following objective findings: <list the findings>. If this additional information does not generate an independent chiropractic review and/or reconsideration and full reimbursement, please provide me with the following answers and information:

1. Your company's definition of medical necessity
2. An outline of what constitutes medical necessity, acute, and chronic care
3. Is input from a doctor of chiropractic considered in these guidelines and applied when reviewing chiropractic claims?
4. Are chiropractic claims reviewed by a licensed doctor of chiropractic (DC) who practices at least 50 percent of the time?
5. The scientific sources and/or literature and citations for the sources that support the decision on this claim

I have acted in good faith to provide this care and to submit this information; in turn, I request that you fulfill your fiduciary responsibility to the patient to provide reasonable, fair, and necessary care under the terms of the policy. Your personal attention in reviewing this situation is appreciated. Please consider this information and provide me with your response within the next 30 days.

Sincerely,

<Doctor's Name>

NCCI Edits Appeal Letter

<OFFICE LETTER HEAD>

<Date>

<Business Name>
<Business Address>

Re: Denial for Services Rendered to <Patient Name> on <Date>
Group #
Policy #
Claim #

To Whom It May Concern:

I have reviewed your letter regarding the above-named patient and have serious concerns about your coding and reimbursement policy as it is not consistent with the American Medical Association's (AMA) *Current Procedural Terminology (CPT®)* coding interpretation.

I am aware that your coding policy reflects the National Correct Coding Initiative (NCCI) edits and feel it necessary to advise you that these edits are not intended for use by third-party payers. In fact, the Medical Director for NCCI, Dr. Niles Rosen, wrote in a letter to the American Chiropractic Association (ACA), "NCCI was not developed with the intent that it be used by third-party payers to process their claims."

Since you may be unaware of this determination, I would appreciate your review and reconsideration of my claim(s) and request a revision of your reimbursement policy. Continued use of incorrect coding policy can be viewed as an unfair claim practice.

I hope to hear from you within 30 days and would appreciate your immediate action on these reimbursement and policy changes.

Sincerely,

<Doctors Name>

Recoupment Appeal

<OFFICE LETTER HEAD>

<Date>

<Business Name>
<Business Address>

Re: Denial for Services Rendered to <Patient Name> on <Date>
Group #
Policy #
Claim #

To Whom It May Concern:

We are in receipt of a refund request in the amount of $_____ for <Date of Service>. According to our records, the claim has been paid accordingly and there is no credit balance on the account. We have applied all appropriate contractual adjustments and the patient has been balance-billed for their responsibility, if any.

According to federal law, as a third-party creditor, we cannot be held liable for mistakes on the insurer's part. We obtained the patient's insurance card, provided at the time of service, and there was no indication that we, as a provider, would not be entitled to 3rd-party payment based on the patient's representation. If you are claiming an overpayment or misapplied benefits, we received the payment and Explanation of Benefits in good faith, and did not bill the patient for the portion covered by the insurance based on your payment and Explanation of Benefits. We have provided services in good faith, and the funds received have been exhausted.

There are several court cases that relate to this circumstance. In 1992, a California case found that, if a provider bills in good faith, and the insurance company accidentally pays them too much through the insurance company's miscalculation, they cannot collect a refund from the provider so long as there was no misrepresentation or fraud on the provider's part in billing: City of Hope Medical Center v. Superior Court of Los Angeles County (1992) 8 Cal.App.4th 633). (Also, Federated Mutual Insurance v Good Samaritan Hospital, Wis. (1994)).

We feel that we have been properly reimbursed for services rendered and no refund will be issued. If, in the future, you elect to deduct the alleged overpayment from future benefits to be paid, we will consult further legal counsel in order to insure that our rights, as indicated by case law, are preserved.

Please do not hesitate to call me if you have any questions or need additional information. You can contact me at <insert contact information>.

Sincerely,

<Doctor's Name>

Timely Filing – Department of Insurance Complaint

<OFFICE LETTER HEAD>

<Date>

<Business Name>
<Business Address>

Re: Denial for Services Rendered to <Patient Name> on <Date>
Group #
Policy #
Claim #

To Whom It May Concern:

I am writing to report a possible violation of <insert: state> insurance regulations. It is my understanding that according to state law, adverse determinations from a utilization review must be transmitted to the treating provider in <enter number of days and cite statute (e.g., Texas Insurance Code 21.58A (5)(2004)>.

When treating <patient>, who is insured by <enter insurer>, I received an adverse determination <#> days after my submission. As this time frame exceeds the response time outlined by state regulation, I felt the Department of Insurance should be notified.

In the attached documentation, I have included the information submitted to the insurer as well as the insurer's response. Please notice the dates on the attached.

If you require additional information, please do not hesitate to contact me at <insert contact information>.

Sincerely,

<Doctor's Name>

Generic Appeal Letter
<OFFICE LETTER HEAD>

<Date>

<Carrier Name>
<Carrier Address>

<RE: Patient Name – DOB>

< Insurance ID #>

<Claim/Reference #> (found on the Explanation of Benefits/EOB)
<Dates of Service and Amount in Question>

I have received your denial for *(insert CPT code/modifier and denial code).* I do not agree with this denial for the following reasons: (*Select one or more or add your own*)

1. Procedure met the indicated guidelines as outlined in the Medical Review Policy.
2. Patient symptoms and documentation supports medical necessity and the level of care rendered (see attached).
3. ICD-10 Diagnosis codes are assigned correctly and considered a covered condition per the Medical Review Policy, (see attached).
4. CPT code assigned is correct and is considered a covered service when rendered by a doctor of chiropractic per the Medical Review Policy (see attached).

I am requesting that you reconsider your prior decision based on the documentation I have attached. This documentation includes:

(Describe what you are attaching. If you are sending patient documentation explain what you believe they may have missed, such as that the patient had an exacerbation, and you've attached the history/exam/diagnosis/treatment plan/outcome assessments that support the episode of care)

Should you determine to uphold your original decision, I am requesting a copy of the internal policies/guidelines used in making this determination along with the reviewer's credentials. Should you need any further information or have any questions, please feel free to call me directly.

Sincerely,

(Doctor's Name)

Authorized Representative