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| APTA Template Letter: Provider to Payer for Denial Based on Code Exclusions |

This template is to be used by the provider to appeal an individual patient denial resulting from a payers exclusion of a specific treatment code.

Insert the applicable information in brackets and create a letter to mail or email to the appropriate agency.

REMINDER: Delete the header, these instructions, and any other bracketed language below prior to submitting your letter.

[DATE]

[NAME/TITLE OF ADDRESSEE]

[INSURER NAME]

[ADDRESS]

Attn: [FIRST/LAST NAME]

Reference Number: [INSERT NUMBER]

[PATIENT NAME, ID#, DATE OF SERVICE]

Re: [HEALTH PLAN] Coding Exclusions

Dear [TITLE/LAST NAME]:

Please accept this letter as a request for [REVIEW, APPEAL, OR OTHER] in response to [HEALTH PLAN]’s unfavorable decision on [DATE] regarding the medical necessity of [DENIED PROCEDURE/SERVICE]. I disagree with the prior authorization denial and request that [HEALTH PLAN] consider reversing its decision. On [DATE] [HEALTH PLAN] implemented coding exclusions that impede my ability to deliver evidence-based, medically appropriate services based on clinical judgment to [HEALTH PLAN] enrollees.

**Background**

[PATIENT’S NAME] presented with [SIGNS/SYMPTOMS/DIAGNOSES/CONDITION] on [DATE]. [EXPLAIN IN NARRATIVE FORMAT THE MEDICAL HISTORY OF PATIENT. INCLUDE MAJOR PROCEDURES/ SURGERIES/DIAGNOSIS/RELEVANT COMORBIDITIES].

Based on my evaluation performed on [DATE], a plan of care was developed to address [PATIENT’S FUNCTIONAL LIMITATIONS/CONDITION]. The denied prior authorized services will adversely impact return to function and ultimately increase the overall cost of care.

**Denied Services**

As part of [PATIENT’S NAME]’s plan of care, [DENIED SERVICE] was deemed appropriate. This requested service was in response to the specific diagnosis(es) of [DIAGNOSIS(ES)]. This service is consistent with generally accepted standards of care. [CITE PEER-REVIEWED MEDICAL LITERATURE IF AVAILABLE]. Furthermore, the services were clinically appropriate and designed to meet the individualized needs of the patient. [LIST TYPE, FREQUENCY, EXTENT, SITE, DURATION OF SERVICES. DISCUSS HOW THE SERVICES WERE CLINICALLY APPROPRIATE WITH REGARD TO EACH FACTOR]. The services are considered effective to improve symptoms associated with [PATIENT’S DIAGNOSIS], specifically [PATIENT’S SYMPTOMS LISTED ABOVE], which [PATIENT’S NAME] is experiencing.

Medically necessary services or supplies are those that are reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. As described above, the denied services meet this standard. I look forward to your reconsideration of this prior authorization decision based on the information provided and consideration to rescind the cited [HEALTH PLAN] policy exclusions. Please do not hesitate to contact me if you have any questions or require additional information.

Thank you for your consideration.

Respectfully submitted,

[NAME]

[ADDRESS]

[TELEHONE]

[EMAIL]

Enclosures:

[LIST ANY ENCLOSURES YOU’RE INCLUDING. IF THERE ARE NO ENCLOSURES, DELETE THIS SECTION.]