

APPEALS – IT'S COMPLEX



- Presented by: Kevin Lasser – September 11, 2025

BIO

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“Lifelong” Michigander

Graduate of
University of Michigan



Exited
Telehealth
Company



CEO – RevKeep
Software

“I invest in technical
solutions that help
people be better at
their jobs and make
their organizations
more profitable”

**Denials
Audits
Require Appeals
They Suck**

BAD PAYOR BEHAVIOR

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Focus on “Complex” Appeals

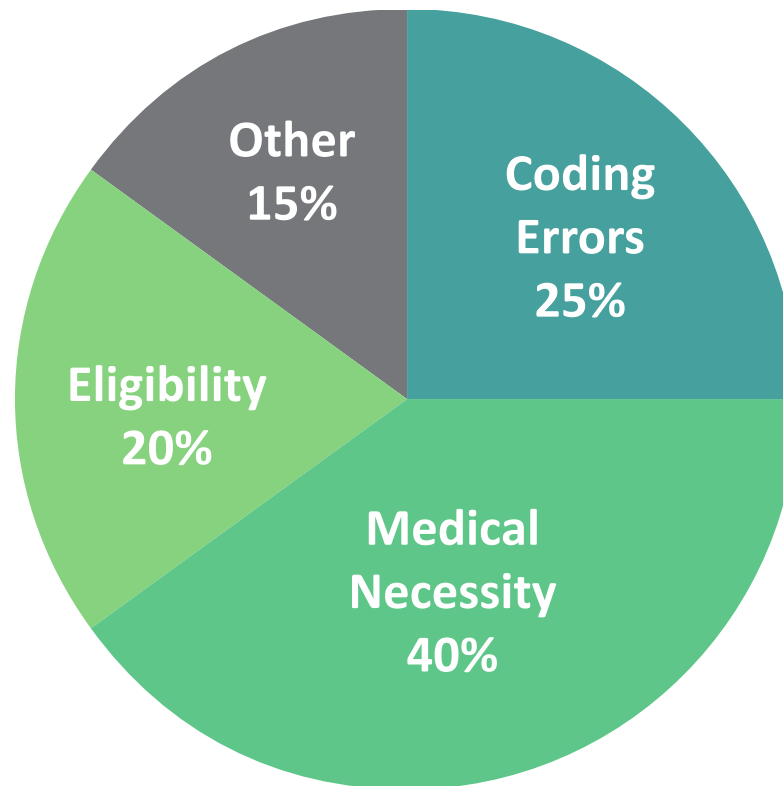
Definition: Requires Medical Records to get paid or retain prior revenue (often requires many people to opine)

Specifically: Up-Front Appeals (medical necessity) and Back End Appeals (Audits)

Requires Medical Expertise

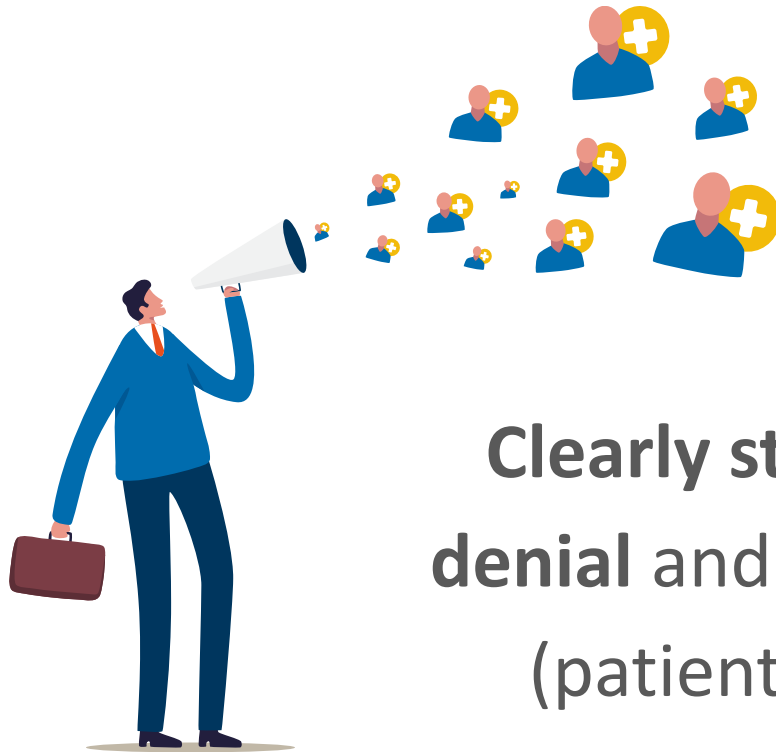
TYPES OF DENIALS

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DRAFTING AN APPEAL LETTER

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Clearly state that you are appealing the denial and provide identifying information (patient's name, policy number, etc.).

UNDERSTAND THE DENIAL

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Review the denial letter
carefully to **understand** the
reasons for the decision.
Identify the **specific policy**
or **guideline** cited by the
insurer.



GATHER DOCUMENTATION

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Collect all relevant medical records, including physician notes, lab results, and treatment plans.

Obtain any prior authorization documents and notes from conversations with the insurer.

Familiarize yourself with the definition of medical necessity as per the insurance policy.

Gather clinical guidelines, studies, or evidence-based literature that supports the need for the treatment or service.



DRAFT THE APPEAL LETTER

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Introduction:

Clearly state that you are appealing the denial and provide identifying information (patient's name, policy number, etc.).

Summary of the Case:

Briefly summarize the patient's medical history and the treatment in question.

Reason for Appeal: Clearly articulate why the treatment is medically necessary, referencing specific medical records and guidelines.

Request for Reconsideration:

Formally request that the insurer review the decision, including a statement of urgency if applicable.

Include Supporting Documentation:

Attach copies of all relevant medical records, correspondence, and any additional evidence that supports your case.

Ensure all documents are clearly labeled and organized.

EXAMPLE OF AN APPEAL LETTER

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Provider and Insurance info:[Practice Name][Your Practice Address][City, State, Zip Code][Phone Number][Email Address][Date][Insurance Company Name][Insurance Company Address][City, State, Zip Code]

Subject: Appeal of Denial for Medical Necessity Patient Name: [Patient Name]Patient ID: [Patient ID/Policy Number]Claim Number: [Claim Number]Date of Service: [Date of Service]

Dear [Insurance Company Appeals Department/Specific Contact Name],

I am writing to **formally appeal the denial of the claim** referenced above for [specific service or treatment], which was rendered to [Patient Name] on [Date of Service]. The claim **was denied on the basis of** medical necessity, as stated in your denial letter dated [Date of Denial Letter].Reason for Denial: The denial letter indicated that the claim was denied due to [specific reason(s) cited by the insurance company, e.g., “the treatment does not meet the criteria for medical necessity”].**Clinical Justification:** I would like to provide additional information to support the medical necessity of the treatment provided:

Medical History:

[Briefly summarize the patient's medical history relevant to the claim, including diagnoses and previous treatments.]

EXAMPLE OF APPEAL LETTER CONT.

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Treatment Rationale:

[Explain the rationale for the treatment, including why it was necessary based on clinical guidelines, the patient's condition, and any relevant medical literature.]

Supporting Documentation:

Attached to this appeal, you will find the following supporting documents:

[List any attached documents, such as clinical notes, test results, treatment plans, or letters from specialists that support the medical necessity.]

Clinical Guidelines:

[Reference any clinical practice guidelines or evidence-based studies that support the treatment as necessary for the patient's condition.]

EXAMPLE OF APPEAL LETTER CONT.

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Conclusion: Given the comprehensive medical history and the necessity of the treatment for [Patient Name], I respectfully request a reconsideration of the claim denial. The treatment provided was essential for the patient's health and well-being, and I believe it meets the criteria for medical necessity as outlined in your policy

Please review the attached documentation and reconsider the claim for payment. Should you require any further information or clarification, please feel free to contact me directly at [Your Phone Number] or [Your Email Address]. Thank you for your attention to this matter. I look forward to your prompt response.
Sincerely,[Your Name][Your Title/Position][Your Practice Name]Attachments: [List of attached documents]

LEVEL OF APPEALS

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There are **several levels of appeal** – they may likely **vary based on payer.**

FIRST-LEVEL APPEAL (INTERNAL APPEAL)

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The provider can file a first-level appeal with the insurance company.

This appeal typically involves **submitting additional documentation or clarifying information to support the medical necessity of the treatment.** This is the most common level of appeal and often involves a review by a claims examiner or nurse.

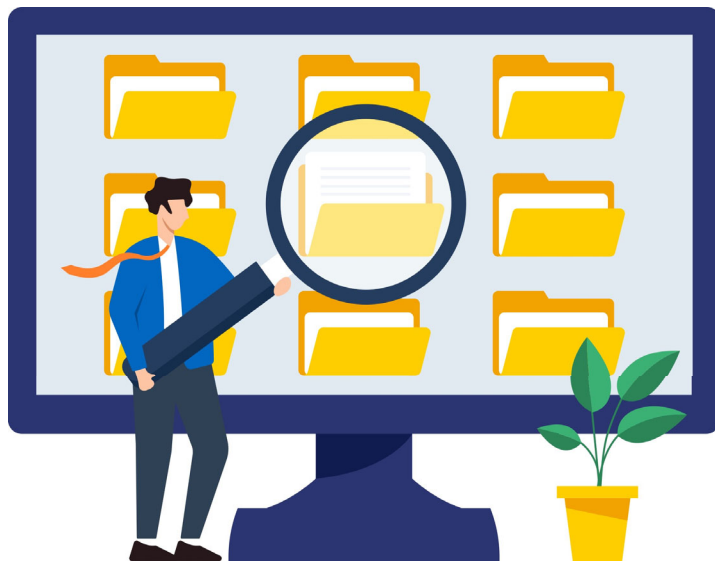


SECOND-LEVEL APPEAL (INTERNAL APPEAL)

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If the first-level appeal is denied, providers may have the option to file a second-level appeal.



This usually involves a **more comprehensive review**, potentially by a **medical director or a higher-level reviewer** within the insurance company. Some insurers have formal processes that allow for this additional level of appeal.

PEER-TO-PEER REVIEW

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In some cases, providers can request a peer-to-peer review, where they have the opportunity to **discuss the case directly with a medical director or reviewer** from the insurance company. This **can occur at any stage** of the appeals process and can be a valuable way to advocate for the medical necessity of the treatment.



EXTERNAL REVIEW

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If both internal appeals are denied, many states provide the option for an external review.



This involves submitting the case to an **independent third-party organization** that reviews the appeal and makes a **binding decision**. This step is often mandated by law, especially for denials based on medical necessity.

LEGAL ACTION

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If all appeals are exhausted and the provider believes the denial was unjust, they may consider pursuing **legal action**. This could involve **litigation or mediation**, depending on the circumstances and the applicable laws.



APPEALING AUDITS

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Money **taken after the fact**
(may go back 5 years)

Private payers and
Government practice it

Referred to as: **RAC audits**,
private payer audits, take
backs, etc

MEDICARE APPEALS PROCESS

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The Medicare Appeals Process is the same for all audits involving Medicare claims, regardless of the contractor who conducted the audit.

1 Redetermination

Providers who are dissatisfied with the contractor's initial determination, which may be in the form of a demand letter, or an indication on the explanation of benefits (EOB), may file a request for redetermination within 120 calendar days from the date the provider received notice of the initial determination.

2 Reconsideration

A provider who is dissatisfied with the redetermination decision may file a request for reconsideration. Reconsideration is conducted by a Qualified Independent Contractor (QIC). The deadline for filing a request for reconsideration is 180 calendar days from the date that the provider received notice of the redetermination decision.

3 Administrative Law Judge (ALJ) Hearing

To preserve the right to an ALJ hearing, a provider must file a written request within 60 days of the date that the provider received notice of the reconsideration decision. ALJ hearings may be conducted in-person, by video-teleconference (VTC) or by telephone. Most are conducted by telephone.

4 Medicare Appeals Council (MAC)

To request a MAC review, a party must file a written request within 60 days of receiving the ALJ decision or dismissal. A party's request for MAC review must identify the parts of the ALJ action with which the party disagrees and explain the reasons for the disagreement. For CMS or its contractors to refer a case for MAC review, the decision or dismissal must, in their view, contain an error of law material to the outcome of the case or must present a broad policy or procedural issue that may affect the public interest.

5 Judicial Review in Federal District Court

Although not a practical option for most healthcare providers, a party to a MAC decision may proceed to a fifth level of appeal in federal district court. A civil action for judicial review must be filed in the U.S. district court for the judicial district in which the party resides or in which the individual, institution or agency has its principal place of business determination, the district court will consider findings of fact by the Secretary of HHS conclusive if supported by substantial evidence.

GROUND ZERO

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600 E. Lafayette Blvd.
Detroit, MI 48226-2998
bcbm.com/medicare

 Blue Cross
Blue Shield
Blue Care Network
of Michigan



Notice of Review Findings

Dear _____,

Blue Cross Blue Shield of Michigan has contracted with HMS for payment integrity services for its Medicare Advantage PPO members. The audit is designed to review the accuracy and integrity of paid claims, including coding validation, payment accuracy, and compliance with regulations, policies, contractual requirements and utilization standards. The information in this letter is confidential and may contain protected health information that may only be disclosed in accordance with HIPAA.

Our review of the services listed in the attached claim(s) showed that Blue Cross overpaid. The audit detail page describes the overpayment and the claim or claim lines involved. Blue Cross will adjust the claim payment(s) as outlined in your provider contract. Protected health information may only be disclosed in accordance with the 45 CFR Parts 160, 162 and 164 (Standards of Privacy of Individually Identifiable Health Information). These improper payments were identified through a variety of methods. The results of our analysis justified reopening your claim, including but not limited to reopening's pursuant to §1869(b)(1)(G) of the Social Security Act and 42 CFR 405.980(a)(1). These results also serve as good cause to reopen the claim if required by 42 CFR 405.980(b)(2).

If you disagree with our findings, you may request a review by providing additional medical information in writing, within 30 days of this notification.

A review of findings request should be sent via fax to the HMS Redetermination Department at 1-702-240-5518. Your request should include the details of the audit findings that you want reviewed and the specific additional information to support your request.

Once we've received your request, we'll conduct a second review and will mail the results to you.

If you have any questions, please contact your HMS Provider Service Representative at (866) 875-1749, Monday through Friday between 8 a.m. and 5 p.m. Pacific Time.

Sincerely,
HMS
Enclosure: Audit Finalization

Additional information:
HMS is an independent corporation retained by Blue Cross Blue Shield of Michigan to conduct reviews of paid Medicare Advantage claims. Blue Cross Blue Shield of Michigan is a non-profit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association. Page 1 of 2

FUR Letter Re: _____



Give them **ONLY** what they ask for
Don't give them more, don't give them less

What did you have for lunch?

Level 1 - REDETERMINATION

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Statistically over 90% go here. Why?

The first level of appeal is redetermination. Providers who are dissatisfied with the contractor's initial determination, which may be in the form of a demand letter, or an indication on the explanation of benefits (EOB), **must file a request for redetermination within 120 calendar days from the date the provider received notice of the initial determination.** However, for post-payment claims, there is another deadline of which providers must be aware. The MAC may begin withholding or recouping from current payments that would be payable to the provider unless the request for redetermination is filed within 30 days of the first demand letter. The redetermination is decided by the MAC.

Level 2 - RECONSIDERATION

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A provider who is dissatisfied with the redetermination decision may file a request for reconsideration. Reconsideration is the second level of appeal in the Medicare appeals process and is **conducted by a Qualified Independent Contractor (QIC)**. The deadline for filing a request for reconsideration is 180 calendar days from the date that the provider received notice of the redetermination decision. As with the redetermination level, providers must be concerned with an additional deadline for post-payment claims. In order to avoid recoupment of the alleged overpayment, the request for reconsideration must be received by the QIC within 60 calendar days of the date of the redetermination decision.

At the reconsideration level, there is an **"early presentation of evidence" requirement**. This means that no additional evidence or documentation will be considered without "good cause" if it is not submitted at the reconsideration. For this reason, it is important to consider all theories of audit defense at this time and submit all potentially relevant evidence so that it is not precluded at the ALJ level.

Level 3 - ALJ HEARING

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The third level of appeal is an **administrative law judge (ALJ)** hearing. In order to preserve the right to an ALJ hearing, a provider must file a written request within 60 days of the date that the provider received notice of the reconsideration decision. ALJ hearings may be conducted in-person, by video-teleconference (VTC) or by telephone. Most are conducted by telephone.

Level 4 - MEDICARE APPEALS COUNCIL

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The fourth level of appeal is the Medicare Appeals Council (MAC) review. In order to request a MAC review, a party must file a written request within 60 days of receiving the ALJ decision or dismissal. A party's request for MAC review **must identify the parts of the ALJ action with which the party disagrees and explain the reasons for the disagreement.** The MAC may also choose to review an ALJ decision or dismissal on its own motion. CMS or its contractors may refer a case to the MAC for consideration on its own motion within 60 days of the date of receipt of an ALJ's decision or dismissal. In order for CMS or its contractors to refer a case for MAC review, the decision or dismissal must, in their view, contain an error of law material to the outcome of the case or must present a broad policy or procedural issue that may affect the public interest.

MAC review of the ALJ decision is de novo and is "on the record", meaning that it does not involve a hearing. Instead, the MAC will give the parties an opportunity to file briefs or written statements, upon request. The MAC's review is limited to the evidence contained in the record of the ALJ proceeding. If the ALJ decision presents a new issue that the parties were not previously afforded the opportunity to address, the MAC will consider any additional submitted evidence that is related to that issue.

The MAC may direct the ALJ to change its decision consistent with the MAC's order. The MAC may also require another hearing. The MAC may also uphold the ALJ's decision if in agreement.

Level 5 - JUDICIAL REVIEW

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Although not a practical option for most healthcare providers, a party to a MAC decision may proceed to a fifth level of appeal in **federal district court**. A civil action for judicial review must be filed in the U.S. district court for the judicial district in which the party resides or in which the individual, institution or agency has its principal place of business determination, the district court will consider findings of fact by the Secretary of HHS conclusive if supported by substantial evidence.

It is not Stopping...

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Just the Facts



“Over half of the RCM leaders report the department is down by 20 or more people”

Payers reporting losses (RUH ROH)

Payers financially incented to continue activity

Denials increasing (on average 15%)

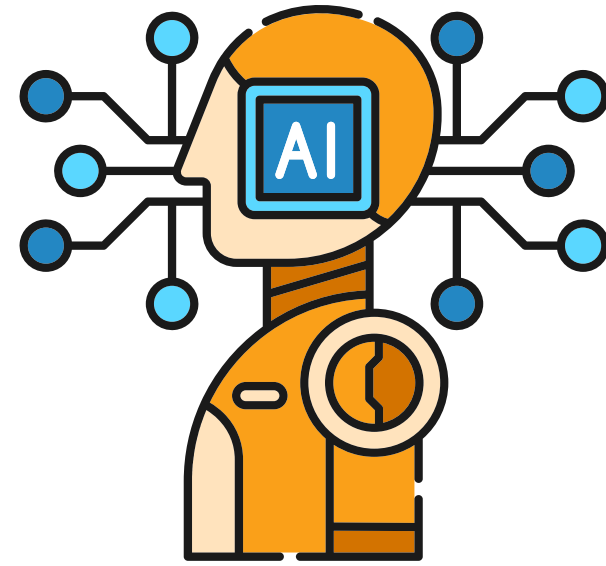
Audits increasing (900% over the last 5 years)

There is this thing called AI

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Would you
bring a knife
to a gun
fight?



I click and
this comes up

Use all **available technologies & education**

You may have the **technology now**

**CRM, email, google share drive,
excel spreadsheets, reports**

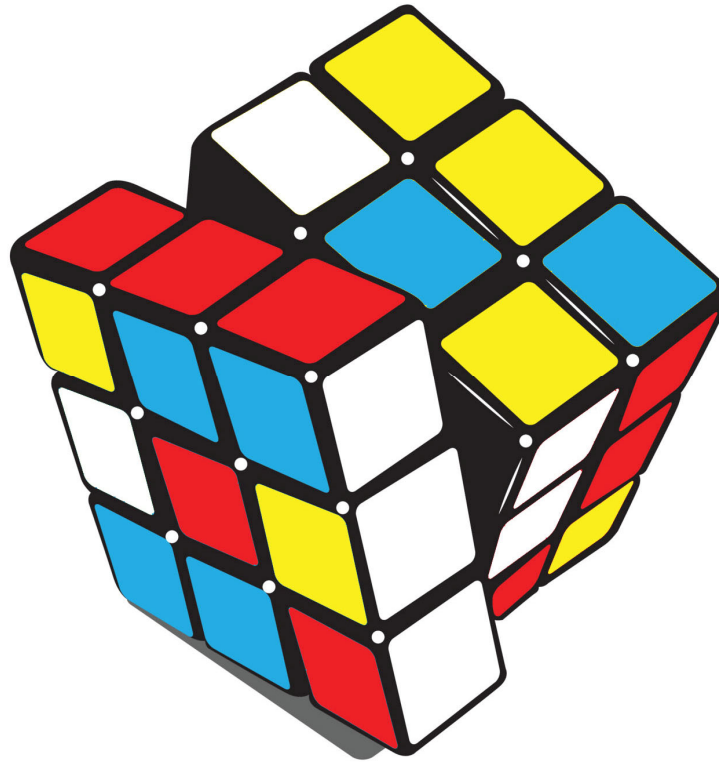
Outsourcing (when needed)

Best Case Scenario –

Integrate to EHR and run reports

REALLY ARE COMPLEX

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A decorative border in a light gray color frames the central text. It features ornate, symmetrical flourishes at the corners and midpoints of the top and bottom edges, with small circular accents at the top and bottom center.

Fin

“It is an unfair fight – let’s level the field”

~Me

All Resources Available to Attendees
Contact Me

Questions?

Kevin Lasser (248) 709-9053

(e): Kevin.Lasser@RevKeepSoftware.com • www.RevKeepSoftware.com