APPEAL LETTER TEMPLATE

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To be considered when appealing a denied claim

**Please understand that all payer’s appeal processes are different. Before you submit an appeal, please review the payer’s appeal process. This letter should not be used in response to medical record requests, corrected claims information, or other administrative denial reasons. If you have any questions, please see the appeal checklist or contact the payer’s provider services representative.**

Instructions for completing the sample appeal letter:

1. Please customize the appeal letter template based on the medical appropriateness. Fields required for customization are in **RED**.
2. It is important to provide the most complete information to assist with the appeal of a claim denial. It is imperative that the doctor who prescribed the test and/or used the test results to manage the patient’s care be the one appealing or be consulted in the appeals process.
3. After you have customized the appeal letter, ***please make sure to delete*** any specific instructions for completion, disclaimers, bioMérieux logos, caution statement, trademarks and document number that are seen throughout the letter, so the health plan does not misinterpret the information.
4. For independent consideration and review, please make all changes that you believe appropriate or disregard these suggestions in their entirety. The customer is ultimately responsible for the accuracy and completeness of all information submitted to third-party payers. Please see the FDA-approved label for information relevant to any prescribing decisions.

**Disclaimer:**

These documents and the information contained herein is for general information purposes only and is not intended, and does not constitute, legal reimbursement, business, clinical or other advice. Furthermore, it does not constitute a representation or guarantee of reimbursement, and it is not intended to increase or maximize payment by any payer. Nothing in this document should be construed as a guarantee by bioMérieux regarding reimbursement or payment amounts, or that reimbursement or other payment will be received. bioMérieux specifically disclaims liability or responsibility and offers no guarantee of coverage, coding, or payment and specifically disclaims liability or responsibility for coding practices of healthcare providers. The customer is solely responsible for determining appropriate charging and billing practices, as well as accurate coding, documentation, and medical necessity for the services provided. This includes the responsibility for accuracy and veracity of all claims submitted to third-party payers. In addition, the customer should note that laws, regulations, and coverage policies are complex and are updated frequently, and, therefore, the customer should check with its local carriers or intermediaries often and should consult with legal counsel or a financial or reimbursement specialist for any questions related to billing, reimbursement, or any related issue. This information does not guarantee coverage or payment at any specific level and bioMérieux does not advocate or warrant the appropriateness of the use of any particular code. It is not provided or authorized for marketing use.

BFR0002-2335-02

[Month, Day, Year]

Attention: Appeals Department Reference Number:[ ] [Payer contact name]

[Payer contact title]

[Facility Name, not necessary if on letterhead or from email] [Address]

[City], [State] [Zip Code]

**RE: Request for Reconsideration of Denied Claim**

Member Name:

Member date of birth:

SS #

Member Identification # Group #

Date of Service

CPT Code: 87507 – Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, *Clostridium difficile*, *E. coli, Salmonella, Shigella*, norovirus, *Giardia*), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types, or subtypes, 12-25 targets

Dear [Payer contact name],

I am writing you today to request reconsideration of the denial of coverage for the above referenced service. The service provided was the medically necessary use of a multi-target gastrointestinal test provided to [patient’s name] on [date of service] for [insert symptoms]. I request to have this claim reconsidered.

Guidelines from American College of Gastroenterology (ACG) and Infectious Disease Society of America (IDSA) support this testing as best practice in the following scenarios: 1) in situations where the patient is at high risk of spreading disease to others, and during known or suspected outbreaks, and 2) in individuals presenting with dysentery, diarrhea with fever, severe abdominal cramps, or signs of sepsis, moderate to severe disease, symptoms lasting >7 days, and immunocompromised patients with diarrhea. ACG also supports the use of FDA-cleared, culture-independent methods because traditional methods of diagnosis fail to reveal the etiology of most cases of acute diarrheal infection.

The FDA-cleared gastrointestinal panel I use can identify 22 bacterial, viral and protozoan pathogens associated with gastroenteritis among patients and I use it as the basis for my diagnosis of a patient. In this case, [insert patient name] presented with [insert symptoms] consistent with gastroenteritis. Because these symptoms can be caused by numerous pathogens, I used the panel to test for the pathogens commonly associated with gastroenteritis.

This panel has shown a positive impact on patient management in my practice, which is why I use this test. Further, it is the only gastrointestinal panel option I have to run on the device. [Please add your assessment of the community use of the product here.]

[Include the following statement if additional information to be attached] In addition, I have attached [relevant excerpts from the patient’s ongoing medical record, a summary of clinical evidence with references from peer-reviewed medical journals, etc.]

I request that you revisit the claim(s) listed above that have been previously denied, as this testing is consistent with ACG and IDSA guidelines, and I followed best practice guidelines in ordering this medically necessary test for my patient, your enrollee.

[If the health plan provides you the option of requesting a peer-to-peer or external review, you may choose to make that request here. Follow the payer’s process for a second or third level appeal. If indicated, request that your appeal is reviewed by an external reviewer or request a peer-to-peer review with an expert in the condition you are diagnosing.]

Thank you for your time and consideration of the above request.

Sincerely,

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[Physician’s name and credentials] [Title]

[Name of practice] [Street address] [City, State, Zip code] [Phone number]

Enclosures:

[Patient medical records/chart notes] [Evidence summary and select literature]

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