

Appeal Strategy Playbooks

Payer-Specific Tactics for Overturning Denied Claims

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1. Appeal Fundamentals

An appeal is a formal request to a payer to reconsider a claim that was denied, reduced, or paid incorrectly. Effective appeals require a structured approach: the right level, the right documentation, and the right timeline. A disorganized appeal process is one of the top reasons organizations leave money on the table.

■ **Key Stat: Organizations with a formal appeals workflow recover 15–25% more revenue than those using ad-hoc approaches. Time-to-submit is the #1 predictor of appeal success.**

Core Principles of a Winning Appeal:

- Submit within deadlines — late appeals are almost universally denied
- Match your argument to the denial reason — do not submit generic letters
- Include all supporting documentation in one submission
- Cite specific payer policy, contract language, or regulatory authority
- Track every appeal: submission date, deadline, outcome, and follow-up date

2. Appeal Levels & Escalation Paths

Most payers have a multi-level appeal structure. Understanding the escalation path — and when to advance to the next level — is critical to maximizing recovery.

Level	Stage	Reviewer	Timeline	Applicable
Level 1	First-Level Reconsideration	Payer internal review	30–60 days	All payer types
Level 2	Second-Level Appeal	Payer senior review / medical director	30–60 days	Commercial, MA, Medicaid
Level 3	External Review / IRO	Independent Review Organization	30–45 days	Commercial (ACA)
Level 4	Peer-to-Peer Review	Physician-to-physician call	Pre/post denial	Clinical denials
Level 5	Medicare Redetermination	MAC review	120 days from EOMB	Medicare FFS
Level 6	ALJ Hearing	Administrative Law Judge	\$200+ threshold	Medicare FFS

3. Commercial Payer Appeal Strategies

Authorization Denials

- Submit auth approval documentation if auth was obtained (fax confirmation, portal screenshot).
- If auth was not obtained, submit retrospective auth request simultaneous with appeal.
- Include clinical notes supporting medical necessity at time of service.
- Cite the plan's emergency/urgent care provisions if applicable.

Timely Filing Denials

- Submit proof of timely filing: original claim submission confirmation, clearinghouse report, or EDI acknowledgment.
- If filing was late, document extenuating circumstances (system outage, patient ID issue).
- Reference any payer-specific timely filing exceptions in the contract.

Medical Necessity Denials

- Request peer-to-peer review within 24–48 hours of denial — this is your highest-ROI action.
- Include physician attestation, H&P, progress notes, and any clinical guidelines (MCG, InterQual).
- Reference the payer's own medical policy language and show how the patient meets criteria.

4. Medicare FFS Appeals

Medicare FFS (Traditional Medicare) has a structured 5-level appeal process governed by CMS. Each level has specific timelines, requirements, and decision-makers.

Level	Reviewer	Deadline	Key Notes
Redetermination	MAC	120 days from EOMB	Submit within 120 days; written request required
Reconsideration	QTSO (MAXIMUS)	180 days from redetermination	Escalate if MAC upholds denial
ALJ Hearing	OMHA	\$200+ in controversy	Request within 60 days of reconsideration
DAB Review	Medicare Appeals Council	60 days from ALJ	Further escalation
Federal Court	U.S. District Court	\$1,760+ threshold (2024)	Final resort; legal counsel recommended

■ **Pro Tip: For Medicare clinical denials, always request an Immediate Review (IR) for inpatient discharge denials before the patient leaves — this preserves your highest-value appeal rights.**

5. Medicare Advantage Appeals

Medicare Advantage (Part C) plans must follow CMS-mandated appeal timelines but have more flexibility in internal processes. MA appeals are often faster than FFS but require close tracking of plan-specific requirements.

Stage	Reviewer	Timeline	Notes
Organization Determination	Plan medical director	72 hrs (expedited) / 14 days standard	Initial decision
Reconsideration	Plan or Independent Review Entity	72 hrs / 30 days	First appeal level
IRE Review	MAXIMUS Federal Services	72 hrs / 30 days	If plan upholds denial
ALJ Hearing	OMHA	\$200+ threshold	Third level

6. Managed Care & Medicaid Appeals

Managed Medicaid and state-regulated MCO appeals vary significantly by state. Key considerations include state fair hearing rights, mandatory external review, and managed care contract provisions.

- **Know your state deadlines** — Medicaid timely filing and appeal windows vary from 90 to 365 days.
- **State Fair Hearing** — Enrollees (and providers acting on their behalf) may request a state fair hearing when an MCO upholds a denial.
- **Contract leverage** — Review your managed care contract for dispute resolution and arbitration clauses.
- **Delegated auth tracking** — Many MCOs delegate auth to sub-contracted entities; ensure appeals go to the correct entity.

7. Appeal Letter Templates & Tips

Every appeal letter should follow a consistent structure. Customize the clinical and policy sections for each specific denial — never submit a generic letter.

Opening Paragraph: Identify patient, DOS, claim number, denial date, and denial reason.

Statement of Appeal: Clearly state you are appealing and cite the level of appeal.

Clinical/Policy Argument: Present your evidence. Cite payer policy, clinical guidelines, and attach supporting documentation.

Conclusion & Request: State the specific action requested (overturn denial, reprocess, approve auth).

Enclosure List: List all attachments. This becomes your submission record.

■ **Writing Tip: Lead with your strongest argument. Reviewers often scan the first paragraph to decide whether to read further. Don't bury your best evidence.**

8. Tracking & Performance Metrics

Metric	Formula / Definition	Target
Appeal Rate	Appeals submitted / Total denials	< 30%
Appeal Success Rate	Denials overturned / Total appeals submitted	> 65%
Avg Days to Submit	Submission date - Denial date (avg)	< 10 days
Recovery Rate	Dollars recovered / Total denied dollars	> 75%
Write-Off Rate	Dollars written off / Total denied dollars	< 5%
P2P Overturn Rate	P2P successes / Total P2P requests	> 55%

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