PLAYBOOKS • v3 • APRIL 2026

Appeal Strategy Playbooks

Four appeals cover 80% of the denials you'll write this quarter. Here's the step-by-step for each one, plus the letter templates you can adapt in under 20 minutes.

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What this is

Most appeals fail for the same reason: they argue the wrong thing. A medical-necessity appeal tries to relitigate an authorization denial. An authorization appeal leaves out the clinical evidence a medical-necessity denial requires. The fix is to match the appeal type to the actual denial reason, then follow a checklist that doesn't skip steps.

This document is four playbooks, one per appeal type. Each has a 5-step workflow, an editable letter template, and the attachments/supporting evidence the payer actually needs. Pair this with the Denial Patterns & Root Causes document to classify the denial before you start.

Pick the right playbook

If the denial says...	Use playbook...	Key evidence
CARC 197 or 198: prior auth missing, expired, or exceeded	01 Authorization	Auth confirmation + dates, peer-to-peer notes, retro-auth request
CARC 29: timely filing limit exceeded	02 Timely Filing	Original 277CA, clearinghouse log, rejection receipts
CARC 50, 167, or 183: not deemed medically necessary	03 Medical Necessity	Op note, imaging, labs, LCD/NCD citation, peer-reviewed support
CARC 97, 234, or 236: bundling or not paid separately	04 Bundling	CCI edit lookup, modifier documentation, op note details

Before you write anything: 3 checks that prevent wasted appeals

- **Is the appeal inside the deadline?** Most commercial payers give 90-180 days from denial. Medicare Part B gives 120 days for redetermination. Start with the deadline, not the letter.
- **Do you have the right evidence?** Each playbook lists required attachments. If you're missing one, get it before drafting. An incomplete appeal resets the clock and weakens the next one.
- **Is this a real denial or an adjustment?** CARC 45 (exceeds fee schedule), CARC 253 (sequestration), and CARC 131 (claim specific negotiated discount) are contract adjustments. Don't appeal; renegotiate.

PLAYBOOK

01 Authorization appeals

TYPICAL WIN RATE
58–72%

WHO USES THIS MOST
Radiology, Orthopaedic Surgery, Pain Management, Physical Medicine and Rehabilitation (procedural)

Authorization denials (CARC 197 and 198) are the most common denial in high-acuity specialties and also the most appealable. In most cases the service was medically appropriate; the authorization just wasn't obtained, attached, or extended correctly. Payers typically allow retrospective authorization for a window after the DOS (Date of Service). If you're inside that window, this is a high-probability win.

The 5-step workflow

1 Confirm what actually happened

Pull the auth record. Was it never requested, requested but denied, approved but expired, approved but for the wrong CPT or date range, or approved but not attached to the claim? Each has a different fix.

2 Request a retroactive authorization

Most commercial payers allow retro-auth inside 14 to 90 days of service. Call the payer's auth line, reference the DOS, and submit clinical support. Document the rep's name and reference ID.

3 Assemble the evidence packet

Include the original auth request (if any), clinical notes supporting medical necessity at the time of service, the denial EOB, and your practice's auth policy showing the request was attempted.

4 Draft the appeal using the letter templates at the back of this document

Open with the facts, cite the auth timeline, attach the packet, close with the specific remedy requested (retro-auth and reprocess). Keep it under 2 pages.

5 Submit through the payer's preferred channel

Portal upload beats fax beats mail. Get a confirmation number. Calendar a 21-day follow-up; if you haven't heard back, escalate to a supervisor.

Red flag to watch for

If the auth was **approved for a different CPT code than the one billed**, review the documentation to determine whether the clinical record supports the authorized CPT or the billed CPT. The appeal path depends on what the documentation actually supports, not on which code is easier to get paid. If the record supports the authorized code, correct the claim accordingly. If the record supports the billed code, appeal on medical-necessity grounds with the clinical evidence that justifies it. Never change a CPT to match an authorization without confirming the documentation supports that code; that is a compliance issue, not a billing shortcut.

PLAYBOOK

02 Timely filing appeals

TYPICAL WIN RATE
62–80%

WHO USES THIS MOST
All specialties; highest volume in groups with clearinghouse handoff issues

Timely filing denials (CARC 29) are frustrating because they are sometimes the payer's error: a rejected submission that was never re-queued, a portal outage, a payer-side intake delay. They are also sometimes the practice's error. If the claim was genuinely filed late, the denial is not appealable. What matters is whether you can prove the claim was submitted on time with a clearinghouse record, not whether you believe it was. Appeals backed by dated evidence win more often than any other type. Appeals without that evidence almost always lose.

Key terms defined

277CA is the Claim Acknowledgement transaction. It's the electronic response a payer or clearinghouse returns confirming a claim was received and either accepted for adjudication or rejected. A 277CA with an acceptance status is your primary evidence of timely submission. **275 transaction** is the electronic Patient Information / Additional Information request and response. Payers may use it to ask for supporting documentation. **DOS** stands for Date of Service. It is the anchor date from which the filing clock usually runs.

The 5-step workflow

1 Pull the submission trail

Clearinghouse log showing the claim was transmitted. 277CA acknowledging receipt. Any rejection reports. Dates of every resubmission. You need timestamps, not summaries.

2 Confirm the payer's timely filing window

Commercial: typically 90 to 180 days from DOS (though some commercial payers allow up to 365 days; always check the specific payer). Medicare Part B: 12 months. State Medicaid: varies. Check the provider manual; the filing clock is measured from the DOS unless a secondary payer exists.

3 Identify why the claim didn't land

Was the claim rejected at the clearinghouse and never corrected? Was it accepted but stuck in a payer batch? Was it submitted to the wrong payer ID? Each needs a different narrative.

4 Draft the appeal with evidence as exhibit pages

Attach clearinghouse logs as labeled exhibits (Exhibit A, B, C). Reference them by exhibit number in the letter; this is how payers audit.

5 **Request the claim be accepted outside the filing window**

Be explicit about the remedy: 'We request that claim [X] be accepted for adjudication outside the timely filing limit based on the submission record attached.'

When timely filing appeals lose

Be honest with yourself first. If the claim genuinely missed the filing window and you have no 277CA, no clearinghouse log, and no rejection report that re-queues the clock, this denial is not appealable. Pursue it as a write-off and fix the workflow that let it slip: daily rejection work queues, a weekly aged-claims report pulled inside each payer's window, and a written follow-up cadence at day 21, 35, and 49. Prevention is where this denial is solved, not at the appeal desk.

PLAYBOOK

03 Medical necessity appeals

TYPICAL WIN RATE
41–58%

WHO USES THIS MOST
Radiology, Physical Medicine and Rehabilitation, Pain Management, Neurology, Cardiology

Medical necessity denials (CARC 50, 167, and 183) are the hardest to appeal because the payer is saying the service wasn't supported. Winning requires clinical evidence the payer didn't have, or didn't weigh correctly, when they denied. Generic appeals lose. Specific, evidence-anchored appeals win.

The 5-step workflow

1 Pull the applicable LCD or NCD

For Medicare and Medicare Advantage, the Local or National Coverage Determination controls. Find it on the MAC website, note the dx/CPT combinations it covers, and identify where your claim fits.

2 Match the documentation to the coverage criteria

The op note, imaging, and labs must explicitly support each element of the LCD. If the LCD requires failed conservative therapy, the chart must show specific therapies tried and failed with dates and outcomes, not 'patient tried conservative care.'

3 Get the rendering provider involved

The strongest medical-necessity appeals are co-signed by the physician who performed the service. A 1-paragraph clinical statement beats a 3-page biller letter every time.

4 Cite peer-reviewed support when the LCD is thin

If the LCD is vague or outdated, attach 1 or 2 current peer-reviewed guidelines (ACR, AMA, or specialty society) that support the clinical decision.

5 Request a peer-to-peer if denied on first appeal

Most payers allow a P2P after a medical-necessity denial. Have the rendering provider do the call, not the biller. Document the reviewer's name, credentials, and specific objections.

The 3-attachment rule

A medical-necessity appeal with fewer than 3 clinical attachments almost always loses. Minimum: (1) full op note or H&P, (2) the imaging/lab report supporting the clinical picture, (3) the LCD/NCD citation or specialty guideline. More isn't better, but less is worse.

PLAYBOOK

04 Bundling appeals

TYPICAL WIN RATE
35–52%

WHO USES THIS MOST
Orthopaedic Surgery, General Surgery, Anesthesiology, Gastroenterology

Bundling denials (CARC 97, 234, and 236) happen when the payer decides a CPT is inclusive of another code billed on the same DOS. Sometimes they're right; CCI edits exist for a reason. When they're wrong, the appeal hinges on whether modifier 59 or the X-modifiers (XE, XS, XP, XU) genuinely apply and whether the documentation supports the distinct service.

The 5-step workflow

1 Run the CCI edit lookup

Go to the CMS NCCI Procedure-to-Procedure (PTP) edits tool at cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-procedure-procedure-ptp-edits. Confirm the edit exists, whether a modifier indicator of 1 allows override, and the effective date. If the indicator is 0, the edit cannot be overridden and the denial is not appealable.

2 Read the op note or procedure note line-by-line

Confirm the two services were genuinely distinct: separate sessions, separate sites, separate providers, or separate indications. If the note doesn't clearly document distinction, the appeal will fail.

3 Determine the correct modifier

Modifier 59 is a last resort. Prefer the X-modifiers when they fit: XE (separate encounter), XS (separate structure), XP (separate practitioner), XU (unusual non-overlapping service).

4 Draft the appeal citing the CCI edit and modifier rationale

Quote the edit, the modifier indicator, and the specific documentation that supports the modifier. Payer reviewers need all three in one place.

5 Request reprocessing with the corrected modifier

Explicitly request reprocessing rather than resubmission. Resubmission often triggers duplicate-claim denials (CARC 18) on top of the bundling denial.

Modifier 59 is a red flag

Modifier 59 is the most audited modifier in the book. Use it only when none of the X-modifiers fit. Payers have pre-pay edits that flag modifier 59 on many code pairs; even a legitimate 59 may pend for review. Document the rationale in the note, not just on the claim.

Escalation & tracking

An appeal that goes into a black hole is a denied appeal. These are the routines that turn individual wins into a repeatable process.

Escalation path when first-level appeal fails

Level	What it is	Typical window
Level 1	Standard appeal using the letter templates at the back of this document.	30-60 days
Level 2	Second-level review with a different clinical reviewer. Include new evidence when possible.	30-60 days
Peer-to-peer	Physician-to-physician call with the payer's medical director. Rendering provider required.	14-30 days
External review	Independent Review Organization (IRO) for fully-insured plans under ACA §2719.	45 days
State insurance complaint	State DOI or Insurance Commissioner. Effective for fully-insured bad-faith denials.	Varies

Tracking that actually changes behavior

A practice that appeals without tracking wins less often over time. Keep these four metrics (by payer and by appeal type) and review monthly:

- **Win rate by appeal type.** If your bundling appeals consistently lose below 30%, the issue is probably documentation, not the letter. Go upstream.
- **Days-to-decision by payer.** Payers that routinely exceed their stated window are candidates for state DOI escalation on repeat offenses.
- **Dollars recovered vs. staff hours spent.** If a payer takes 2+ hours of staff time per $500 appeal and wins 30% of the time, that's a losing economic trade. Escalate or renegotiate.
- **Repeat CARCs.** If the same CARC is in your top 5 for 3 months running, it's a process problem. Appeals are the downstream fix; the upstream fix is in eligibility, coding, or auth workflow.

The companion document

> For the denial classification side of the equation (including practice-type denial profiles and the top 15 CARCs with EDI Lab deep links) see the Denial Patterns & Root Causes document at roithatworks.com/denials-appeals-library.

SECTION 02

Editable letter templates

These four templates cover the four most common appeal types. Each is designed to be printed as is and filled in by hand, or copied into a word processor and edited on screen. Bracketed fields in **teal** mark the spots that must be customized for each claim. Everything outside brackets is standard language that works across most payers.

How to use:

- Replace every bracketed field with the claim-specific detail. Do not leave brackets in the final letter.
- Attach the exhibits listed at the end of each template. An appeal missing its exhibits almost always loses.
- Keep the letter to 2 pages or fewer. Reviewers spend 2 to 4 minutes per appeal; brevity wins.
- Submit through the payer's preferred channel. Portal upload beats fax; fax beats mail. Record the confirmation number.
- Calendar a 21-day follow-up. If there is no response, escalate to a supervisor by name.

A note on formatting

These templates use monospace type so the layout survives copy-paste into any word processor. Once you paste, feel free to re-style the text in your practice's preferred font. Keep the section headings, exhibit labels, and the remedy-requested block; those are the structural elements payer reviewers look for.

EDITABLE TEMPLATE

Authorization appeal

Use this template for CARC 197 or 198 denials. Pair with Playbook 01 (page 3).

```
[Practice Letterhead]
[Date]

[Payer Name] Appeals Department
[Payer Address]

RE: Appeal of Claim Denial (Authorization)
      Patient: [Patient Name] | DOB: [MM/DD/YYYY]
      Member ID: [Member ID] | Claim #: [Claim Number]
      Date of Service: [DOS] | CPT: [CPT Code]
      Denial Reason: CARC 197 or 198

To Whom It May Concern:

This letter serves as a formal appeal of the denial of the above
claim. We are requesting that the claim be reprocessed with a
retroactive authorization for the following reasons:

1. TIMELINE OF AUTHORIZATION ATTEMPTS
   - [Date]: Authorization requested via [method].
     Reference number: [ref #].
   - [Date]: [Response or lack of response from payer].
   - [DOS]: Service rendered. Clinical necessity documented
     in attached progress note.

2. CLINICAL JUSTIFICATION
   The service was medically indicated on the date rendered
   based on [1-2 sentence clinical summary tied to the
   diagnosis and symptom burden]. Supporting documentation
   is attached, including [list: op note, imaging report,
   H&P, etc.].

3. REMEDY REQUESTED
   We request that [Payer Name] issue a retroactive
   authorization for CPT [Code] on [DOS] and reprocess
   claim [Claim #] for payment.

Please contact our office at [phone] with questions.
Thank you for your prompt attention to this matter.

Sincerely,

[Name, Credentials]
[Title] | [Practice Name]

ATTACHMENTS:
  [ ] Original authorization request (if applicable)
  [ ] Denial EOB
  [ ] Clinical notes supporting necessity
  [ ] Imaging/lab reports (if applicable)
```

EDITABLE TEMPLATE

Timely filing appeal

Use this template for CARC 29 denials. Pair with Playbook 02 (page 4). Requires 277CA or clearinghouse log.

```
[Practice Letterhead]
[Date]

[Payer Name] Appeals Department
[Payer Address]

RE: Appeal of Claim Denial (Timely Filing)
      Patient: [Patient Name] | DOB: [MM/DD/YYYY]
      Member ID: [Member ID] | Claim #: [Claim Number]
      Date of Service: [DOS]
      Denial Reason: CARC 29 (Timely Filing Limit Exceeded)

To Whom It May Concern:

We are appealing the denial of the above claim on timely
filing grounds. The enclosed documentation demonstrates that
the claim was submitted within [Payer]'s [XX]-day filing
window:

SUBMISSION TIMELINE:

   [DOS + X days] Initial submission via [clearinghouse].
                  Exhibit A: Clearinghouse transmission
                  log confirming acceptance.

   [Date] 277CA received confirming claim accepted
                  by payer. Exhibit B.

   [Date] [Any subsequent events: rejection,
                  resubmission, outage notices.] Exhibit C.

   [Date] Denial EOB received. Exhibit D.

Per the timeline above, the claim was submitted [X] days after
the date of service, well within the [XX]-day filing window
stated in Section [X] of the provider manual.

REMEDY REQUESTED:
We request that claim [Claim #] be accepted for adjudication
and reprocessed for payment based on the timely submission
record attached.

Sincerely,

[Name, Credentials]
[Title] | [Practice Name]

ATTACHMENTS:
  Exhibit A: Clearinghouse transmission log
  Exhibit B: 277CA acknowledgement
  Exhibit C: Rejection reports / resubmission log (if any)
  Exhibit D: Denial EOB
```

EDITABLE TEMPLATE

Medical necessity appeal

Use this template for CARC 50, 167, or 183 denials. Pair with Playbook 03 (page 5). Co-sign with rendering provider.

```
[Practice Letterhead]
[Date]

[Payer Name] Medical Appeals Department
[Payer Address]

RE: Appeal of Claim Denial (Medical Necessity)
      Patient: [Patient Name] | DOB: [MM/DD/YYYY]
      Member ID: [Member ID] | Claim #: [Claim Number]
      Date of Service: [DOS] | CPT: [CPT Code]
      Diagnosis: [ICD-10 Code and description]
      Denial Reason: CARC 50 (Not Medically Necessary)

To Whom It May Concern:

This letter, co-signed by the rendering physician, appeals
the medical-necessity denial of the above service. The service
was clinically indicated and meets the coverage criteria in
[Payer] LCD/NCD [Number and Title].

1. CLINICAL BACKGROUND
   [2-4 sentence summary: patient's presentation, relevant
   history, conservative treatments attempted and outcomes,
   and the clinical reasoning for the service billed.]

2. ALIGNMENT WITH COVERAGE CRITERIA
   [Payer] LCD/NCD [Number] covers [CPT Code] when:
      a) [Criterion 1] → Met: [how documentation shows it]
      b) [Criterion 2] → Met: [how documentation shows it]
      c) [Criterion 3] → Met: [how documentation shows it]

   See Exhibits A (op note) and B (imaging) for specific
   documentation of each criterion.

3. SUPPORTING CLINICAL EVIDENCE
   [Specialty society guideline or peer-reviewed source
    supporting the clinical decision. 1-2 citations.]

4. REMEDY REQUESTED
   We request that [Payer] reverse the medical-necessity
   denial and reprocess claim [Claim #] for payment. If
   this appeal is denied, we request a peer-to-peer review
   with a reviewer of matched specialty.

Sincerely,

[Rendering Physician Name, MD/DO] [Biller Name, CPB]
[Practice Name] [Practice Name]

ATTACHMENTS:
  Exhibit A: Full progress note / operative report
  Exhibit B: Imaging or lab report
  Exhibit C: LCD/NCD citation
  Exhibit D: Peer-reviewed guideline (if applicable)
```

EDITABLE TEMPLATE

Bundling appeal

Use this template for CARC 97, 234, or 236 denials. Pair with Playbook 04 (page 6). Run NCCI PTP lookup first.

```
[Practice Letterhead]
[Date]

[Payer Name] Appeals Department
[Payer Address]

RE: Appeal of Claim Denial (Bundling)
      Patient: [Patient Name] | DOB: [MM/DD/YYYY]
      Member ID: [Member ID] | Claim #: [Claim Number]
      Date of Service: [DOS]
      CPTs Billed: [Primary CPT] and [Secondary CPT]
      Denial Reason: CARC 97 (Bundled or Inclusive)

To Whom It May Concern:

This letter appeals the bundling denial of CPT [Secondary
Code] billed with CPT [Primary Code] on [DOS]. The services
were distinct and separately billable.

1. CCI EDIT REVIEW
   Per the CMS NCCI PTP edit file ([quarter/year]):
      - Column 1 Code: [Primary CPT]
      - Column 2 Code: [Secondary CPT]
      - Modifier Indicator: 1 (override allowed with
        appropriate modifier)
      - Effective Date: [MM/DD/YYYY]

2. DOCUMENTATION OF DISTINCT SERVICES
   The operative/procedure note documents that the two
   services were performed as follows:
      - [Primary CPT]: [brief description of site/encounter]
      - [Secondary CPT]: [distinct site/encounter/indication]
   See Exhibit A, op note sections [X] and [Y].

3. MODIFIER APPLIED
   Modifier [XE / XS / XP / XU / 59] was appended to CPT
   [Secondary Code] to indicate [specific rationale, e.g.,
   'separate anatomical structure' for XS].

4. REMEDY REQUESTED
   We request that [Payer] reprocess claim [Claim #] with
   the modifier as submitted and reimburse CPT [Secondary
   Code] separately from CPT [Primary Code].

Sincerely,

[Name, Credentials]
[Title] | [Practice Name]

ATTACHMENTS:
  Exhibit A: Operative / procedure note
  Exhibit B: NCCI edit lookup screenshot
  Exhibit C: Denial EOB
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Mindy built **Revenue Optimization & Intelligence** to help specialty practices and billing companies stop losing revenue to denials that were preventable on the front end. Credentials: Certified Scrum Product Owner, Certified Professional Coder, Certified Professional Biller, and Certified Physician Practice Manager. Her public work focuses on denial prevention, appeal strategy, payer rule drift, and the operational systems that keep clean claims clean.

Explore the EDI Lab →	Live CARC / RARC / CAGC lookups.	www.roithatworks.com/edi-lab.html
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