COMPREHENSIVE GUIDE

HARRIS CareTracker
A Harris Healthcare Company

Preventing & Appealing Insurance Claim Denials

Checklists, Prevention Strategies, and Sample Appeal Letters for Medical Billing and RCM Teams

Includes: CPT/ICD Code Verification | Prior Authorization Tracking
Patient Data Accuracy | Documentation Checklists | Appeal Letter Templates

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Section 1: The Denial Landscape

Insurance claim denials remain one of the most significant threats to provider revenue. Understanding current trends and root causes is the first step toward building a durable prevention strategy.

1 in 5	$262B	85%	62%+
Claims denied on first submission	Denied claims annually (US)	Of denials are preventable	Appeal success rate with proper docs

According to the 2025 Experian Health State of Claims report, 76% of denials are driven by missing, incomplete, or inaccurate data.The top three denial categories are missing or inaccurate data, missing authorizations, and incomplete patient information.KFF data shows insurers denied 19% of in network claims and 37% of out of network claims in 2023, the highest rates since tracking began in 2015.

Why Denials Are Increasing

- Payer rule complexity continues to grow, with frequent mid year policy updates
- AI powered payer auditing algorithms flag minor discrepancies automatically
- Telehealth coding requirements have tightened with new modifier mandates
- CMS digital prior authorization rules take effect in 2026, requiring early preparation
- Bundled care models (CCM, RPM) create overlapping code conflicts

Two Categories of Denials

- Soft Denials: Temporary rejections that can often be corrected and resubmitted (missing codes, documentation gaps, data entry errors)
- Hard Denials: Permanent rejections that are typically not recoverable (missed filing deadlines, non covered services, credentialing lapses)

Section 2: Top 10 Claim Denial Reasons

The following table summarizes the most common denial reasons, their typical root causes, and proven prevention strategies. Each reason is ranked by frequency of occurrence.

#	Denial Reason	Root Cause	Prevention Strategy
1	Missing or Inaccurate Patient Information	Wrong DOB, policy number, member ID, or spelling errors from rushed intake	Verify demographics at every visit. Use real time eligibility tools integrated with your EHR.
2	Missing Prior Authorization	PA not obtained, expired, or attached to wrong service/payer	Maintain a PA tracking log. Flag PA required services at scheduling. Verify auth before DOS.
3	Expired or Inactive Insurance	Coverage lapsed, job change, or COB not updated	Run eligibility checks within 48 hours of appointment. Re verify at check in.
4	Incorrect Coding or Modifier Use	Outdated CPT/ICD codes, missing modifiers, diagnosis/procedure mismatch	Regular coding audits. Use claim scrubbers. Follow NCCI edits for bundling.
5	Duplicate Claims	Same claim submitted multiple times due to tracking gaps	Implement claim tracking software. Establish a 72 hour wait before resubmission.
6	Bundled Services	Services billed separately that should be grouped under one code	Stay current on payer specific bundling rules. Run NCCI edits pre submission.
7	Lack of Medical Necessity	Insufficient clinical justification or diagnosis does not support procedure	Ensure documentation clearly supports necessity. Link ICD to CPT with clinical rationale.
8	Timely Filing Limit Exceeded	Claims submitted after payer deadline due to backlogs or system issues	Submit claims within 24 to 48 hours of service. Automate deadline alerts by payer.
9	COB Errors	Multiple insurers, confusion about primary vs secondary payer	Verify primary and secondary payer details at each visit. Update COB at registration.
10	Credentialing Issues	Provider not active with payer or revalidation lapsed	Maintain a credentialing log. Set reminders for revalidation every 2 to 3 years.

Section 3: CPT/ICD Code Verification Checklist

Coding errors account for a significant share of preventable denials. Use this checklist before every claim submission to ensure CPT, ICD 10, and HCPCS codes are accurate and compliant.

Code Currency and Updates

[ ] Confirm you are using the current year CPT code set (AMA updates effective January 1 annually)

[ ] Confirm you are using the current ICD 10 CM code set (CMS updates effective October 1 annually)

[ ] Review any mid year code additions, deletions, or revisions from AMA or CMS bulletins

[ ] Verify HCPCS Level II codes are current for supplies, DME, and Medicare specific services

[ ] Subscribe to payer alert feeds for code specific policy changes

Code Selection and Specificity

[ ] Select ICD 10 codes at the highest level of specificity available (laterality, severity, stage)

[ ] Verify each CPT/HCPCS code matches the procedure or service actually performed per documentation

[ ] Confirm diagnosis to procedure linkage: each CPT code is paired with an ICD 10 code that justifies it

[ ] Avoid using unspecified ICD 10 codes when clinical detail supports a more specific code

[ ] For E/M services, verify the code level matches documented medical decision making complexity or time

Modifier Compliance

[ ] Apply appropriate CPT modifiers (25, 59, 76, 77, RT/LT, 26, TC) based on clinical scenario

[ ] Verify modifiers do not conflict with NCCI bundling edits

[ ] Confirm payer specific modifier acceptance rules (some payers reject certain modifier combinations)

[ ] For bilateral procedures, apply modifier 50 or RT/LT per payer preference

Bundling and Edit Checks

[ ] Run claims against NCCI (National Correct Coding Initiative) edits before submission

[ ] Identify any mutually exclusive procedure pairs and resolve before filing

[ ] Confirm add on codes are submitted with appropriate primary procedure codes

[ ] Check for incidental services that should not be billed separately

[ ] Validate place of service code aligns with the CPT code billed

Medical Necessity Linkage

[ ] Verify the ICD 10 diagnosis code supports medical necessity for each CPT code billed

[ ] Check LCD (Local Coverage Determinations) and NCD (National Coverage Determinations) for the service

[ ] Confirm documentation includes a clear clinical decision and medical necessity statement

[ ] For high cost services, verify payer specific coverage criteria are met before submission

Medicare Tip

Medicare uses LCD and NCD databases to determine covered services. Always cross reference your CPT/ICD pairing against the applicable LCD for your MAC (Medicare Administrative Contractor) jurisdiction before filing. CMS maintains the Medicare Coverage Database at cms.gov/medicare-coverage-database.

Commercial Plan Tip

Commercial payers often maintain their own medical policy bulletins that may differ from Medicare criteria. Check each payer's provider portal for their current coding guidelines, especially for advanced imaging, genetic testing, and specialty pharmaceuticals.

Section 4: Prior Authorization Prevention and Tracking Checklist

Prior authorization denials often originate at scheduling, registration, or ordering rather than in billing. The following checklist addresses prevention at every stage of the workflow.

At Scheduling

[ ] Determine whether the ordered service, procedure, or referral requires prior authorization

[ ] Verify the specific CPT/HCPCS codes that will be billed and confirm they match the PA request

[ ] Identify the correct payer for the authorization (primary vs. secondary)

[ ] Check for payer specific requirements: clinical notes, referral forms, supporting labs or imaging

[ ] Assign clear ownership of the PA request to a named staff member

Submitting the PA Request

[ ] Submit the PA request using the payer's preferred method (portal, fax, phone)

[ ] Include all required clinical documentation with the initial submission

[ ] Verify patient demographics match the payer's records exactly (name, DOB, member ID)

[ ] Document the submission date, method, and reference or tracking number

[ ] Set a follow up reminder for 48 to 72 hours after submission

Before Date of Service

[ ] Confirm the PA is approved and the authorization number is on file

[ ] Verify the approved service matches the CPT/HCPCS codes, place of service, and provider on the claim

[ ] Confirm the authorization date range covers the scheduled date of service

[ ] Check that the number of approved visits or units has not been exhausted

[ ] If the service changes intraoperatively, verify whether a modified or new PA is required

PA Tracking Log (Recommended Fields)

Maintain a centralized PA tracking log with the following data points for every authorization request:

Field	Description
Patient Name and ID	Full name, DOB, and insurance member ID
Payer Name	Insurance company and plan type
Service Requested	CPT/HCPCS codes and procedure description
PA Submission Date	Date the request was submitted to the payer
Submission Method	Portal, fax, or phone with reference number
PA Status	Pending, Approved, Denied, or Expired
Authorization Number	Payer issued auth number once approved
Approved Date Range	Start and end dates of the authorization window
Approved Units/Visits	Number of visits or units authorized
Staff Assigned	Name of the person responsible for tracking this PA
Follow Up Dates	Scheduled check in dates to confirm status
Notes	Denial reason, appeal status, peer to peer outcome

High Risk Services Requiring PA Vigilance

- Advanced imaging (MRI, CT, PET, nuclear medicine)
- Surgical procedures, especially outpatient and ambulatory
- Specialty pharmaceuticals and infusion therapy
- Durable medical equipment (DME) above threshold dollar amounts
- Physical therapy, occupational therapy, and speech therapy beyond initial visits
- Genetic and molecular testing
- Behavioral health and substance use treatment

Medicare Tip

Medicare Advantage plans require prior authorization for many services that Original Medicare does not. Always verify PA requirements directly with the patient's specific MA plan. CMS is implementing new electronic prior authorization rules that take effect in 2026.

Commercial Plan Tip

Commercial payers update their PA required service lists frequently, sometimes mid year. Check the payer portal monthly and subscribe to provider bulletins. Many commercial plans require PA for advanced imaging even when the referring physician is in network.

Section 5: Patient Data Accuracy Checklist

Eligibility and patient data errors are the number one preventable cause of denials. This checklist should be completed at registration and re verified at every visit.

Patient Demographics

[ ] Verify full legal name (first, middle, last) exactly as it appears on the insurance card
[ ] Confirm date of birth matches payer records
[ ] Verify gender/sex as listed with the insurance plan
[ ] Update current address, phone number, and email
[ ] Confirm Social Security Number (if required by payer)
[ ] Verify relationship to subscriber (self, spouse, dependent)

Insurance Verification

[ ] Scan or photograph the front and back of the current insurance card
[ ] Verify insurance plan name, policy number, and group number
[ ] Confirm the subscriber name and subscriber ID if different from the patient
[ ] Run real time eligibility verification within 48 hours of the appointment
[ ] Re verify eligibility at check in on the date of service
[ ] Confirm effective date and termination date of coverage
[ ] Document the eligibility verification reference number and date

Coordination of Benefits (COB)

[ ] Ask the patient if they have more than one insurance plan
[ ] Determine primary, secondary, and tertiary payer order
[ ] Verify COB information is current and matches payer records
[ ] For workers' compensation or auto accident cases, obtain the appropriate payer information
[ ] Update COB at every visit, especially at the beginning of a new plan year

Consent and Compliance Documents

[ ] Obtain signed HIPAA privacy acknowledgment
[ ] Collect signed Assignment of Benefits (AOB) form
[ ] For Medicare patients, issue an Advance Beneficiary Notice (ABN) when services may not be covered
[ ] Obtain informed consent for procedures
[ ] Document the name and title of the staff member who verified all information

Medicare Tip

Medicare requires the ABN (Advance Beneficiary Notice, CMS Form R 131) to be issued before services are rendered when there is reason to believe Medicare will not cover the service. Failure to issue an ABN means the provider cannot bill the patient for the non covered amount.

Commercial Plan Tip

Many commercial plans now require real time eligibility verification through EDI 270/271 transactions. If your practice management system supports it, enable automated eligibility checks that run the night before each scheduled appointment.

Section 6: Documentation Completeness Checklist

Incomplete documentation is a leading cause of hard denials that cannot be overturned. Use this checklist to verify that every claim has the supporting documentation payers require.

Clinical Documentation

[ ] Chief complaint and reason for visit clearly stated

[ ] Complete history of present illness (HPI) documented

[ ] Physical examination findings or assessment recorded

[ ] Clinical decision making process and plan of care documented

[ ] Medical necessity statement connecting diagnosis to the service provided

[ ] For time based services: start time, end time, and total duration documented

[ ] Relevant lab results, imaging findings, or test results referenced or attached

Provider Signatures and Authentication

[ ] Provider signature present on all documentation (electronic or handwritten)

[ ] Supervising physician co signature present when required (residents, NPs, PAs)

[ ] Date and time of signature matches or is close to the date of service

[ ] Provider credentials and NPI number included

Procedure and Surgical Documentation

[ ] Operative report completed within required timeframe (typically 24 hours)

[ ] Procedure description matches the CPT code billed

[ ] Anesthesia type and duration documented

[ ] Complications or intraoperative changes documented

[ ] Pathology and specimen documentation attached when applicable

Claim Form Completeness (CMS 1500 or UB 04)

[ ] All required fields populated (patient info, provider info, diagnosis, procedure codes)

[ ] Date of service matches the documentation

[ ] Place of service code is correct and matches the encounter setting

[ ] Referring provider NPI included when required

[ ] Prior authorization number entered in the appropriate field (Box 23 on CMS 1500)

[ ] Claim type and bill type correct for institutional claims

Pre Submission Review

[ ] Run automated claim scrub for CPT/ICD validation and edit checks

[ ] Verify diagnosis to procedure consistency across all line items

[ ] Confirm no duplicate claims exist for the same patient, date, and service

[ ] Review high dollar claims manually before submission

[ ] Confirm payer specific documentation requirements are met

Section 7: The Appeals Process

Fewer than 1% of denied claims are appealed, yet well documented appeals succeed 62% to 74% of the time. A structured appeals workflow recovers significant revenue that would otherwise be written off.

Step 1: Review the Denial (Day 1)

- Read the entire Explanation of Benefits (EOB) or Electronic Remittance Advice (ERA)
- Identify the specific CARC and RARC codes and the written denial reason
- Determine whether this is a soft denial (correctable) or hard denial (requires formal appeal)
- Note the appeal deadline, required documents, and submission method from the denial notice
- Classify the denial type: administrative, coding, medical necessity, authorization, or eligibility

Step 2: Investigate the Root Cause (Day 1 to 2)

- Pull the original claim, medical records, and all supporting documentation
- Compare the billed codes to the documentation to identify any mismatch
- Verify eligibility and authorization status on the date of service
- Check for data entry errors on the claim form
- Determine if this is a payer error (misapplied policy) or a provider error (missing information)

Step 3: Gather Evidence (Day 2 to 3)

- Compile complete medical records supporting the service
- Obtain a letter of medical necessity from the treating provider
- Locate applicable clinical guidelines (AMA, specialty society, peer reviewed literature)
- Pull the payer's own medical policy or coverage determination that supports the service
- Gather any prior authorization approval documentation
- Prepare a comparison of plan language vs. the payer's denial rationale

Step 4: Write and Submit the Appeal (Day 3 to 5)

- Draft the appeal letter using the appropriate template from Section 8
- Address the specific denial reason point by point with evidence
- Attach all supporting documentation, clearly labeled and referenced in the letter
- Submit via the payer's preferred method (portal, fax, certified mail)
- Keep copies of everything submitted, including proof of delivery

Step 5: Follow Up and Escalate (Ongoing)

- Confirm receipt within 3 business days of submission
- Request the name of the assigned reviewer
- Follow up at 5, 10, and 15 day intervals
- Request a peer to peer review when the denial involves medical necessity
- If the internal appeal is denied, file an external review within the required timeframe
- For Medicare: follow the five level appeal process (Redetermination, QIC, ALJ, Council, Federal Court)

Appeal Timelines

Type	Standard Deadline	Expedited Option	Decision Timeline
Internal Appeal	30 to 180 days from denial	24 to 72 hours (urgent)	30 days (standard), 72 hours (expedited)
External Review	Within 4 months of final internal denial	Available for urgent cases	45 days (standard), 72 hours (expedited)
Medicare Redetermination	120 days from initial determination	72 hours (expedited)	60 days (standard)
Medicare QIC Reconsideration	180 days from redetermination	72 hours (expedited)	60 days (standard)

Section 8: Sample Appeal Letters by Denial Type

The following templates provide a structured starting point for the most common denial categories. Customize each letter with the specific facts of your case, supporting evidence, and payer policy citations. Every appeal letter should directly address the stated denial reason with precision.

A. Medical Necessity Denial Appeal

[Date]

[Insurance Company Name]
Provider Appeals Department
[Address]
[City, State, ZIP]

RE: Appeal of Medical Necessity Denial
Patient Name: [Patient Name]
Member ID: [Member ID]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
CPT Code(s): [CPT Code(s)]
ICD 10 Code(s): [ICD 10 Code(s)]
Denial Date: [Denial Date]

Dear Medical Director,

I am writing to formally appeal the denial of [procedure/service name] (CPT [code]) for the above referenced patient. Your denial notice dated [date] states that the service was denied because [quote the exact denial reason from the EOB].

Clinical Summary:
[Patient Name] is a [age] year old [male/female] who presented with [diagnosis and relevant history]. The patient has been under my care since [date] for [condition]. Relevant clinical findings include [list specific exam findings, lab values, imaging results, and symptoms].

Prior Treatment History:
The patient has previously undergone the following conservative treatments: [list previous treatments with dates and outcomes]. Despite these interventions, the patient's condition has [describe progression or lack of improvement].

Medical Necessity Justification:
The requested service is medically necessary because [explain clinical rationale]. This is supported by the following evidence:
1. [Cite specific clinical guideline, e.g., AMA, AAP, ACR, or specialty society recommendation]
2. [Cite peer reviewed literature supporting the service for this diagnosis]

3. [Reference the payer's own medical policy, if applicable, and explain how the patient meets stated criteria]

Plan Language Review:
The patient's benefit plan [plan name] covers [service type] when medical necessity is established. The clinical evidence provided demonstrates that the criteria outlined in your medical policy [policy name/number, if known] are met.

I respectfully request that this claim be reconsidered for payment. Please forward this appeal to a board certified [relevant specialty] physician for medical review. I am available for a peer to peer discussion at [phone number].

Should additional information be required, please contact [staff name] at [phone number].

Sincerely,
[Provider Name], [Credentials]
[Practice Name]
NPI: [NPI Number]

Enclosures:
1. Explanation of Benefits (denial notice)
2. Complete medical records for dates of service
3. Letter of medical necessity
4. Relevant clinical guidelines and literature
5. Payer medical policy excerpt (if applicable)

B. Prior Authorization Denial Appeal

[Date]

[Insurance Company Name]
Prior Authorization Appeals Department
[Address]
[City, State, ZIP]

RE: Appeal of Prior Authorization Denial
Patient Name: [Patient Name]
Member ID: [Member ID]
Prior Authorization Request Number: [PA Number]
Requested Service: [Procedure Name] (CPT [Code])
Denial Date: [Denial Date]

Dear Appeals Review Committee,

I am writing to formally appeal the denial of prior authorization for [service/procedure name] (CPT [code]) for the above referenced patient. Your denial notice dated [date] states the request was denied because [quote exact denial reason].

Patient Clinical Presentation:
[Patient Name] is a [age] year old [male/female] diagnosed with [primary diagnosis, ICD 10 code]. Current symptoms include [list symptoms with severity indicators]. Relevant diagnostic findings include [lab values, imaging results, exam findings].

Treatment History and Step Therapy Compliance:
The patient has completed the following treatments as required by your step therapy protocol:
1. [Treatment 1]: [dates], [outcome]
2. [Treatment 2]: [dates], [outcome]
3. [Treatment 3]: [dates], [outcome]

Despite completing these conservative measures, [describe why the requested service is now necessary].

Clinical Guideline Support:
The requested service is supported by [cite clinical guidelines, society recommendations, and peer reviewed evidence]. The patient meets the following criteria from your medical policy [policy name/number]:
[List each criterion and explain how the patient meets it]

Urgency Statement:
[If applicable: This appeal requires expedited review. Standard processing timeframes would seriously jeopardize this patient's health because (specific medical reasons). Delayed treatment will result in (specific adverse outcomes).]

I respectfully request immediate approval of prior authorization for [specific service]. I am available for a peer to peer discussion at [phone number] and can provide any additional clinical information needed.

Sincerely,
[Provider Name], [Credentials]
[Practice Name]
NPI: [NPI Number]

Enclosures:
1. Prior authorization denial notice
2. Clinical notes and treatment history
3. Diagnostic test results (labs, imaging)
4. Letter of medical necessity
5. Clinical guidelines and peer reviewed literature
6. Payer medical policy excerpt

C. Administrative or Coding Error Appeal

[Date]

[Insurance Company Name]
Claims Appeals Department
[Address]
[City, State, ZIP]

RE: Appeal of Claim Denial Due to Administrative/Coding Error
Patient Name: [Patient Name]
Member ID: [Member ID]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
CARC Code: [Code] | RARC Code: [Code]
Denial Date: [Denial Date]

Dear Claims Review Department,

I am writing to appeal the denial of the above referenced claim. The denial notice dated [date] cites [CARC code and description] as the reason for non payment.

Error Identification and Correction:
Upon review, we have identified the following error on the original claim submission:
[Describe the specific error, e.g., incorrect modifier, wrong place of service code, missing authorization number, data entry error]

Corrected Information:
The correct information is as follows:
[Provide the corrected data point(s), with specifics]

The enclosed corrected claim form and supporting documentation demonstrate that the service was provided, was covered under the patient's benefit plan, and meets all requirements for reimbursement.

Please reprocess this claim with the corrected information. If you require additional documentation, please contact [staff name] at [phone number].

Sincerely,
[Provider Name or Billing Manager Name]
[Practice Name]
NPI: [NPI Number]

Enclosures:
1. Original denial notice (EOB/ERA)
2. Corrected CMS 1500 or UB 04 claim form
3. Supporting medical documentation
4. Proof of eligibility on date of service (if applicable)

5. Authorization documentation (if applicable)

D. Timely Filing Denial Appeal

[Date]

[Insurance Company Name]
Claims Appeals Department
[Address]
[City, State, ZIP]

RE: Appeal of Timely Filing Denial
Patient Name: [Patient Name]
Member ID: [Member ID]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Denial Date: [Denial Date]

Dear Claims Review Department,

I am writing to appeal the denial of the above referenced claim on the basis of timely filing. Your denial notice states the claim was received after the filing deadline.

Proof of Timely Submission:
[Choose the applicable scenario:]

Scenario A: Claim was originally filed on time
The original claim was submitted on [date] via [method: EDI, portal, mail] within the [X] day filing deadline. Enclosed is [proof of submission: electronic confirmation, fax receipt, certified mail receipt, clearinghouse transmission report] demonstrating timely filing.

Scenario B: Delay was caused by circumstances beyond our control
The delay in filing was caused by [explanation: incorrect insurance information provided by the patient, late notification of COB, system outage, retroactive eligibility change, or other documented circumstance]. We filed the claim within [X] days of obtaining correct information on [date].

I respectfully request that this claim be reprocessed for payment consideration based on the evidence of timely filing or extenuating circumstances.

Sincerely,
[Provider Name or Billing Manager Name]
[Practice Name]

Enclosures:

1. Original denial notice
2. Proof of original submission date
3. Supporting documentation of filing delay cause (if applicable)
4. Complete claim with all required documentation

Section 9: Common Denial Codes Quick Reference

The following table lists the most frequently encountered CARC (Claim Adjustment Reason Codes) with their meanings and recommended corrective actions.

Code	Description	Common Cause	Corrective Action
CO 4	Missing Modifier	Required modifier not included or applied incorrectly	Review modifier, correct, and resubmit. If correct, appeal with documentation.
CO 11	Incorrect Coding	Diagnosis or procedure codes do not match service	Review all codes, correct errors, and resubmit.
CO 15	Missing Authorization	PA missing or entered incorrectly in Box 23	Verify auth number. Request retro auth if possible. Appeal with proof.
CO 16	Claim Lacks Information	Required data fields missing or incomplete	Identify missing data from RARC, complete, and resubmit.
CO 18	Duplicate Claim	Same claim submitted more than once	Verify original claim status. If unique service, appeal with documentation.
CO 22	COB Required	Coordination of benefits information needed	Verify primary/secondary payer. Submit COB information.
CO 27	Expired Coverage	Insurance inactive on date of service	Confirm coverage dates. Bill correct payer or patient.
CO 29	Filing Limit Exceeded	Claim filed after payer deadline	Provide proof of timely filing or extenuating circumstances.
CO 50	Not Medically Necessary	Payer deems service clinically unjustified	Appeal with clinical documentation, guidelines, and peer reviewed evidence.
CO 96	Non Covered Charge	Service not covered under patient's plan	Review plan terms. Determine if denial is a misapplied rule vs. true exclusion.
CO 109	Not Covered by Payer	Service excluded from plan benefits	Verify plan language. If misapplied, appeal with benefit documentation.
CO 197	Precertification Not Obtained	Precertification or notification required but not received	Obtain retro authorization if allowed. Appeal with clinical justification.
CO 236	Not Separately Payable	Service bundled with another procedure on same day	Review NCCI edits. Use appropriate modifier if service is distinct.
CO 256	POS Mismatch	Procedure code inconsistent with place of service	Verify correct POS code. Correct and resubmit.

Section 10: Payer Specific Filing Deadlines

Timely filing requirements vary significantly by payer. The following table provides general guidelines. Always confirm current deadlines directly with each payer, as these can change.

Payer	Initial Filing Deadline	Appeal Deadline	Notes
Medicare (Original)	1 year from DOS	120 days (Redetermination)	Five level appeal process. Strict deadlines at each level.
Medicare Advantage	1 year from DOS (varies by plan)	60 days from denial	PA requirements vary by plan. Verify with each MA plan.
Medicaid	Varies by state (90 days to 1 year)	Varies by state	Check your state Medicaid agency for specific rules.
Blue Cross Blue Shield	90 to 365 days (varies by plan)	60 to 180 days from denial	Rules vary by local BCBS plan. Verify on provider portal.
UnitedHealthcare	90 to 180 days	180 days from denial	Electronic submission preferred. Check plan specifics.
Aetna	90 to 180 days	180 days from denial	Verify by plan type. Self funded plans may differ.
Cigna	90 to 365 days	180 days from denial	Check network participation agreement for specifics.
Humana	90 to 180 days	180 days from denial	Medicare Advantage products follow MA appeal rules.
Tricare	1 year from DOS	90 days from denial	Follow DHA appeal procedures for reconsideration.
Workers' Comp	Varies by state	Varies by state	State specific. May require different appeal forms.

Important Reminder

The filing deadlines listed above are general guidelines based on typical payer contracts. Self funded employer plans, carve out specialty plans, and plans administered by third party administrators may have different deadlines. Always verify the specific filing and appeal deadlines in your provider contract or on the payer's provider portal.