APPENDIX E
FLOW CHARTS AND SAMPLE APPEAL LETTERS

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- *Correct Coding Initiative Flow Chart*
- *Correct Coding Initiative Letters (CCI-1, CCI-2)*
- *Dental Downcoding Third Molars Flow Chart*
- *Dental Downcoding Third Molars Letters (DC-1, DC-2)*
- *Services Not Covered When Performed by This Provider Flow Chart*
- *Services Not Covered When Performed by This Provider Letters (DP-1, DP-2, DP-3, DP-4)*
- *Anesthesia By Surgeon Flow Chart*
- *Anesthesia By Surgeon Letters (GA-1, GA-2)*
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- *Temporomandibular Joint Services Letters (TMJ-1, TMJ-2, TMJ-3, TMJ-4)*

SAMPLE APPEAL LETTER
INTRODUCTION

The following sample appeal letters are provided as model language for appealing some of the most common denials of claims submitted by oral and maxillofacial surgeons. In some instances, the sample language provided could be used in its entirety. At other times, only the applicable points should be adapted. In all cases, between the address and the closing, an appeal letter should contain the following:

Date

Name
Address of Insurance Carrier

RE: Patient's Name
Subscriber's Name
Subscriber's ID#
Date of Service
Claim # (when applicable)

Dear________________________:

The opening paragraph of your appeal letter should be to request review of the insurance carrier's previous decision regarding the denial of coverage for (insert name of surgical procedure being denied) performed on the above patient.

The concluding paragraph should thank the carrier for its consideration and offer to provide additional information to assist the re-evaluation of this claim. A copy of all correspondence to the carrier regarding unwarranted denials should be sent to both the patient/enrollee of the policy and the employer via the Human Resources Manager. The "cc:" in your letter will make the carrier realize that you are keeping the patient/enrollee and the employers informed of the dispute.

Advice for your guidance is presented in bold italics and is not to be used in letters to insurance carriers.

Closing,

Doctor's Name and Degree(s)

SAMPLE APPEAL LETTER

AMEND AN INSURANCE CLAIM FORM

Date

Insurance Company
Address

RE: Insured Name:
ID No:
Patient Name:
Date of Service:
Claim No:

To Whom It May Concern:

Please find enclosed an amended dental/health claim form for my patient, your insured ***insert patient name*** for services performed on ***insert date of service***. The original claim was submitted with incorrect Procedural/Diagnostic coding. The services performed were ***(describe in detail procedure performed) and should have been coded with CDT/CPT code (insert diagnosis code). The diagnosis code for this procedure is (insert diagnosis code for Medical claim).***

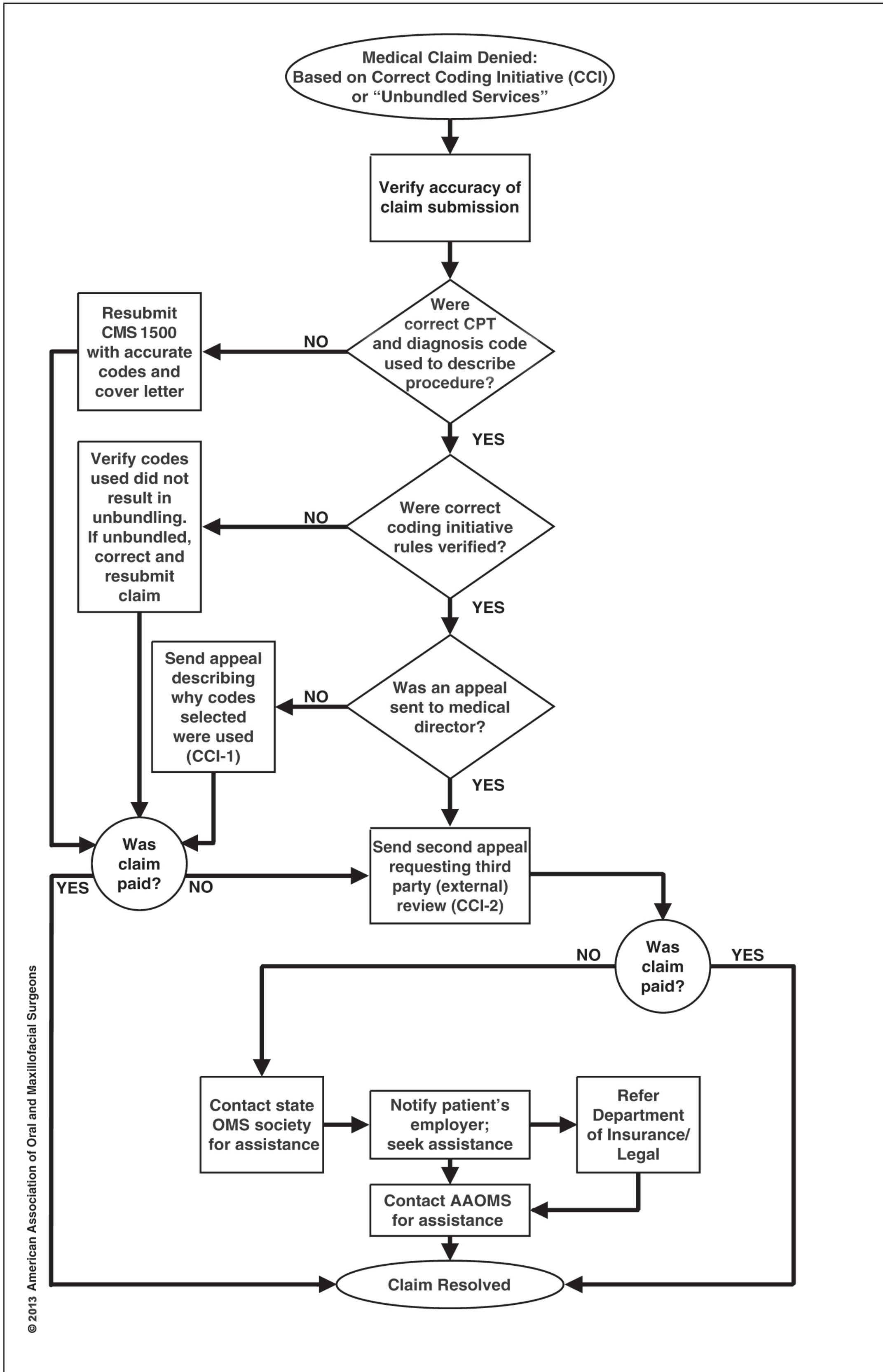
Thank you in advance for your attention to this administrative error. I am enclosing an ***operative note/ patient history, etc. which would support the reassigning of the new code*** for your review. Please do not hesitate to contact me should you have any questions or concerns regarding this information.

Sincerely,

OMS Name and Degree

ENCL:

FLOW CHART
CORRECT CODING INITIATIVE



SAMPLE APPEAL LETTER
CORRECT CODING INITIATIVE (CCI-1)

Date

Medical Director
Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

Dear Dr. ***insert Medical Director Name:***

I am requesting an appeal of a claim that has been denied for my patient, your insured, ***insert patient name***. The services performed were denied based on ***insert exact wording*** which I have translated to mean that the codes used were, in your opinion "unbundled." I disagree with this determination and offer the following information.

The CPT code, ***insert code and descriptor***, accurately defines the procedure that was performed and is the code that I would consider to be the primary procedure. CPT code ***insert additional CPT code,*** was also performed and reported correctly. Although, the procedures were performed at the same surgical setting, they are not inherent of one another and should not be bundled as this does not accurately reflect what was done. The diagnosis codes used, ***insert ICD-9-CM codes***, must be reviewed and consideration given to each diagnosis independent of the other. I am enclosing an operative report for your review and record.

While I recognize that unbundling does occur within the healthcare industry, I assure you that I have reviewed the Correct Coding Initiative and am confident that this claim was submitted to you accurately and appropriately. I am confident that additional benefits will be released once you have had the opportunity to review and correct this administrative error. Thank you for allowing me the opportunity to clarify the procedures that were performed and the rationale behind respective billings.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor

SAMPLE APPEAL LETTER
CORRECT CODING INITIATIVE (CCI-2)

Date

Medical Director
Insurance Carrier
Carrier Address

RE: ***Patient Name***
Patient I.D.
Date of Service

Dear Dr. ***insert Medical Director Name:***

I am requesting reconsideration of a claim that has been denied for my patient, your insured, ***insert patient name***. The denial states that services were not approved based on ***insert exact wording from claim denial.*** I continue to disagree with this determination and am requesting a third party or external review be performed by a licensed oral and maxillofacial surgeon who is trained to perform the following procedure(s): ***insert procedure(s)***.

Again, the CPT codes, ***insert code and descriptor***, accurately defines the procedure that was performed and is the code that I would consider to be the primary procedure. CPT code ***insert additional CPT code***, was also performed and reported correctly. Although, the procedures were performed at the same surgical setting, they are not inherent of one another and should not be bundled as this does not accurately reflect what was done. The diagnosis codes used, ***insert ICD-9-CM codes*** must be reviewed and consideration be given to each diagnosis independent of the other. I am enclosing an operative report for review by a third party representative.

As previously stated, I recognize that unbundling does occur within the healthcare industry, I assure you that I have reviewed the Correct Coding Initiative and am confident that this claim was submitted to you accurately and appropriately. I look forward to receiving a written response from an independent party who is trained and qualified to perform the aforementioned procedure(s).

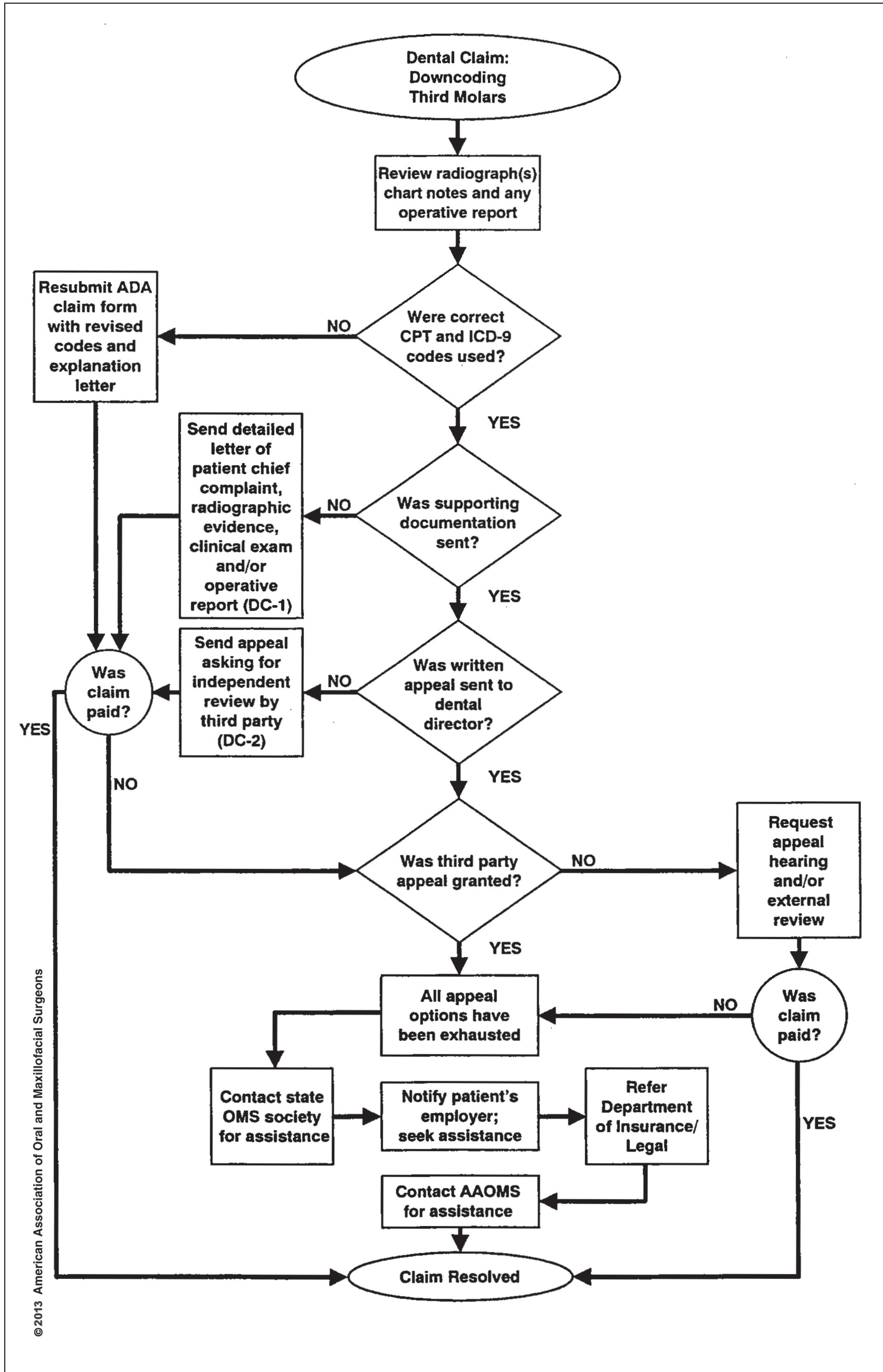
Sincerely,

OMS Name and Degree

cc: ***Patient/Guarantor***
Employer
State OMS Society
AAOMS Reimbursement Manager

FLOW CHART

DENTAL DOWNCODING THIRD MOLARS



SAMPLE APPEAL LETTER

DENTAL DOWNCODING THIRD MOLARS (DC-1)

Date

Dental Director
Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

Dear Dr. ***insert Dental Director Name:***

I am requesting an appeal of a claim that has been denied for my patient, your insured, ***insert patient name***. The services performed were denied based on ***insert exact wording from claim denial.*** I disagree with this determination and offer the following information.

The CDT code ***insert code(s) and descriptor along with associated tooth no.***, accurately defines the procedure that was performed and is the code that corresponds with the patient's medical record. I am enclosing an operative report and panorex radiograph for your review and record. While I recognize that overcoding may be a problem and does occur within the healthcare industry, I assure you that I have reviewed the recommendations put forth by state and national organizations and am confident that this claim was submitted to you accurately and appropriately.

I welcome the opportunity to discuss this matter with you and encourage you to send the enclosed supporting information to an independent third party for review. Thank you for allowing me the opportunity to disagree with your interpretation of my billing records. I look forward to your review and the proper adjudication of these services.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor

4/13

SAMPLE APPEAL LETTER

DENTAL DOWNCODING THIRD MOLARS (DC-2)

Date

Dental Director
Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

Dear Dr. ***insert Dental Director Name:***

I am requesting an independent review of appeal of a claim that has been denied for my patient, your insured, ***insert patient name***. The services performed were denied based on ***insert exact wording from claim denial.*** I disagree with this determination and am requesting an independent review.

I am enclosing the American Association of Oral and Maxillofacial Surgeons' recently revised *Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParCare 2012)* chapter relating to dentoalveolar surgery and the *AAOMS Clinical Condition Statement on The Management of Impacted Third Molar Teeth* to assist you in reviewing this claim.

Removal of asymptomatic impacted third molars is the preferred treatment if there is insufficient anatomic space to accommodate normal eruption. The timely removal of impacted third molar teeth at an early age is a scientifically sound treatment rationale based on medical necessity. There have been numerous published articles supporting the removal of third molars to prevent risks or conditions associated with retaining them. The decision to leave teeth in place should be based on scientifically valid evidence. I am unaware of any scientific literature which supports your contention that the removal of the impacted teeth is not medically necessary.

The CDT code originally submitted, ***insert code(s) and descriptor along with associated tooth no***., accurately defines the procedure that was performed and is supported by documentation within the patient's medical record. I am enclosing an operative report and panorex radiograph for your review and record. While I recognize that overcoding does occur within the healthcare industry, I assure you that I have reviewed the recommendations put forth by state and national organizations and am confident that this claim was submitted to you accurately and appropriately.

I welcome the opportunity to discuss this matter with you and encourage you to send the enclosed supporting information to an independent third party for review. Thank you for allowing me the opportunity to disagree with your interpretation of my billing records. I look forward to your review and the proper adjudication of these services.

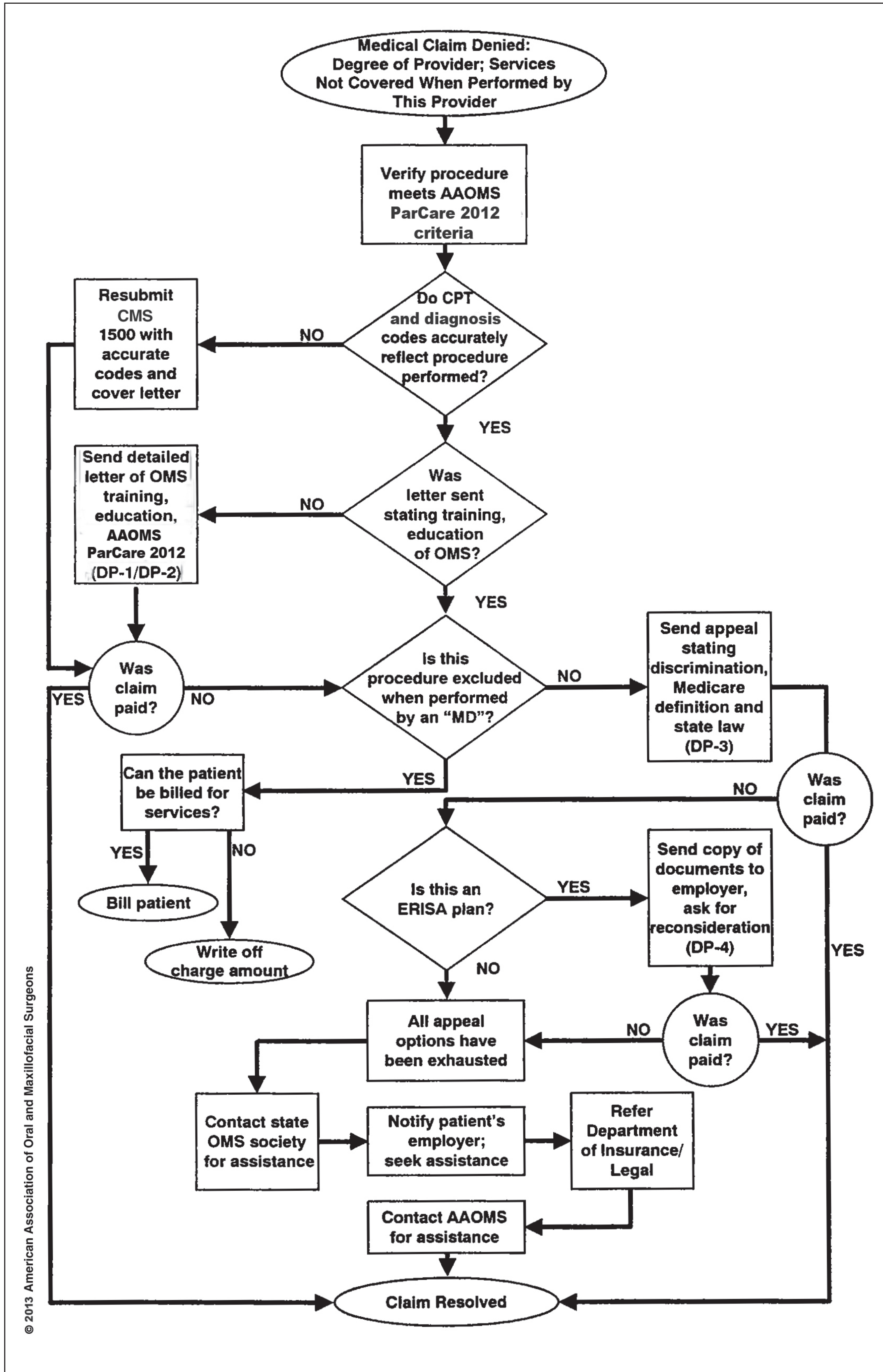
Sincerely,

OMS Name and Degree

cc: Patient/Guarantor
Employer
State OMS Society President
AAOMS Reimbursement Manager

FLOW CHART

SERVICES NOT COVERED WHEN PERFORMED BY THIS PROVIDER



SAMPLE APPEAL LETTER

SERVICES NOT COVERED WHEN PERFORMED BY THIS PROVIDER (DP-1)

Date

Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

To Whom it May Concern:

I have recently received a written denial for services provided to my patient, ***insert patient name***. It is my understanding based on this information that ***insert insurance carrier name*** is unable to process benefits on behalf of my patient because I am an oral and maxillofacial surgeon. The explanation of benefits reads ***insert exact wording from EOB.*** I am requesting that this "policy" be reviewed and benefits be allowed since as a ***board certified*** oral and maxillofacial surgeon, I have been trained and am fully licensed to perform these surgical services. The services provided by me were ***insert procedure name and reason for performing the procedure.***

The specialty of oral and maxillofacial surgery is recognized through the American Dental Association and its House of Delegates and is defined as follows:

"Oral and maxillofacial surgery is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region."

According to both the American Medical Association and the Joint Commission, criteria used for delineating clinical privileges should be objectively applied and relate to an individual's training, competence, experience and training. The same principle should be applied when benefit determination for a patient is being decided rather than an apparently arbitrary judgment which reflects no understanding of the accepted scope of practice of an oral and maxillofacial surgeon both in ***insert state*** and nationally.

I am requesting that you review the current policy of excluding oral and maxillofacial surgeons from providing these services and issue reimbursement accordingly. Thank you in advance for your attention to this very important matter, and I look forward to receiving your response.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor

4/13

SAMPLE APPEAL LETTER
SERVICES NOT COVERED WHEN PERFORMED BY THIS PROVIDER (DP-2)

Date

Medical Director Name and Title
Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

Dear Dr. ***insert Medical Director Name:***

I have received a second denial for services that I provided to my patient, ***insert patient name***. It continues to be my understanding that ***insert insurance carrier name*** will not approve this claim because I am an oral and maxillofacial surgeon. I have previously requested that this "policy" be reviewed and benefits allowed, but this has not happened. Furthermore, it has come to my attention that these same surgical services would, in fact, be covered if performed by one of my colleagues, specifically an ***insert specialty (ENT, plastics, etc)***. As a ***board certified*** oral and maxillofacial surgeon, I have been trained and am fully licensed to perform these surgical services. The services provided by me were ***insert procedure name and reason for performing the procedure.***

Employers, insurance carriers, healthcare organizations and credentialing committees often are not familiar with oral and maxillofacial surgery training and scope of practice. The oral and maxillofacial residency programs entail four years of dental school followed by a minimum of 48 months of full-time training in a hospital-based residency. The American Dental Association (ADA) Commission on Dental Accreditation, which accredits the residency programs, is a nationally recognized accrediting body approved by the U.S. Department of Education and the Liaison Council on Medical Education. The training of oral and maxillofacial surgeons is focused on treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the maxillofacial area. The training for oral and maxillofacial surgeons includes the following:

- All residents are required to complete a core surgical year.
- Oral and maxillofacial surgeons are trained extensively in the management of hard and soft tissue injuries of the face, including facial esthetic/cosmetic surgery, trauma, nasal, orbital, nasoethmoidal, and malar fractures. Repair of associated or independent soft tissue injuries is an important part of this training, as is the thorough understanding of the wound healing process and contracture of wounds. Rotations to the surgery and medicine services provide additional background.
- The oral and maxillofacial surgery training standards clearly identify training in reconstructive surgery, including bone and soft tissue grafting, involvement in comprehensive case management, management of continuity defects, facial cleft repair, and craniofacial surgery.
- Oral and maxillofacial surgeons are required to be trained in the harvesting of bone and soft tissue grafts.
- Oral and maxillofacial surgeons complete training in independent maxillofacial esthetic procedures, including malar augmentation, genioplasty, liposuction, and a variety of "lifting" procedures, including cervicofacial rhytidectomy, rhinoplasty, blepharoplasties, scar reconstructions, dermabrasions, and laser.

Insert Patient Name
Insert Patient I.D.

Autologous procedures require obtaining grafts, fat or other tissues from the patient's body to complete some of the esthetic surgery that the oral and maxillofacial surgeon is trained to perform.

Insurance plans, including i***nsert name of plan***, should not base reimbursement simply on the degree of the provider. Rather, plans should determine scope of practice-related reimbursement policies on meaningful objective standards, including Joint Commission criteria and state law. Those standards recognize that a provider's scope of practice must be determined on multiple criteria, including professional education, training, competence, and experience.

Enclosed are the following documents that substantiate the training that oral and maxillofacial surgeons receive and contain information that might broaden one's knowledge of this specialty:

- American Dental Association Commission on Dental Accreditation B *Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery*
- American Association of Oral and Maxillofacial Surgeons and the American Board of Oral and Maxillofacial Surgery (AAOMS/ABOMS) *Statement on the Training and Practice of Oral and Maxillofacial Surgery*
- *Comparison of OMS Education and Training to Medical Specialties*
- *Competencies of the Oral and Maxillofacial Surgeon at the Completion of Training*
- *Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParCare 2012)*

Again, I am requesting that the practice of excluding oral and maxillofacial surgeons from providing these services be stopped and reimbursement for these services be allowed.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor
Patient/Guarantor Employer
State OMS Society President
AAOMS President
AAOMS Reimbursement Manager

SAMPLE APPEAL LETTER

SERVICES NOT COVERED WHEN PERFORMED BY THIS PROVIDER (DP-3)

Date

Medical Director Name and Title
Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

Dear Dr. ***insert Medical Director Name:***

I have received a second denial for services that I provided to my patient, ***insert patient name***. It continues to be my understanding that ***insert insurance carrier name*** will not approve this claim because I am an oral and maxillofacial surgeon. I have previously requested that this "policy" be reviewed and benefits allowed, but this did not happen. Furthermore, it has come to my attention that these same surgical services would, in fact, be covered if performed by one of my colleagues, specifically an ***insert specialty (ENT, plastics, etc)***. As a ***board certified*** oral and maxillofacial surgeon, I have been trained and am fully licensed to perform these surgical services. The services provided by me were ***insert procedure name and reason for performing the procedure.***

Sections 1861(r) of the Social Security Act contains the provisions of Medicare which prohibit the denial of payment based on the academic degree of the provider performing services. Under Medicare, the definition of physician includes doctor of dental surgery or medicine who is legally authorized to practice medicine in the state in which these functions are performed. Such services include any otherwise covered service that may legally and alternatively be performed by doctors of medicine, osteopathy and dentistry. The coverage or exclusion of any given dental service is not affected by the professional designation of the "physician" rendering the services, eg, an excluded dental service remains excluded and a covered dental service is still covered whether furnished by a dentist or doctor of medicine or osteopathy. I have enclosed a copy of Medicare and Medicaid statutes which contain the definition of physician. Moreover, the state of ***insert state and following statement if true*** prohibits discrimination of reimbursement based on the professional degree of the provider if the procedure performed is within the provider's scope of practice.

The American Association of Oral and Maxillofacial Surgeons (AAOMS) and the American Board of Oral and Maxillofacial Surgery (ABOMS) *Statement on the Training and Scope of Practice of the Oral and Maxillofacial Surgeon* describes the education and training of oral and maxillofacial surgeons, their field of practice and credentialing/ privileges. This document is useful in understanding the full scope of an oral and maxillofacial surgeon's practice.

Based on the information I have provided you, I will expect your company representatives to refrain from making any discriminatory statements against OMSs as to what services we are not qualified to perform when, in fact, these procedures are within our scope of training and license. I appreciate your immediate attention to this matter and I look forward to the approval of these benefits and the immediate release of payment for these services.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor
Patient/Guarantor Employer
State OMS Society President
AAOMS President
AAOMS Reimbursement Manager

SAMPLE APPEAL LETTER

SERVICES NOT COVERED WHEN PERFORMED BY THIS PROVIDER (DP-4)

Date

Employer Name and Address
ATTN: Human Resources Manager
Address

RE: Employee (Patient) Name
Employee I.D.
Date of Service

Dear Dr. ***insert Human Resources Manager Name:***

On behalf of my patient, ***insert patient name*** I am requesting that special consideration be given by ***insert employer name*** for benefits previously denied by ***insert name of third party carrier. Insert patient name*** has provided me with written authorization allowing me to share ***his/her*** necessary health information with you for the purpose of appealing this denial.

Insert patient name underwent ***insert procedure*** for the ***insert treatment and diagnosis and/or condition***. The reason for the denial, as stated by the third party administrator, was because I am an oral and maxillofacial surgeon. This is an obvious case of discrimination based on my degree and license. I have previously requested that this "policy" be reviewed and benefits allowed, but this did not happen. Furthermore, it has come to my attention that these same surgical services would be covered if performed by one of my colleagues, specifically an ***insert specialty (eg, ENT, plastics)***. As a ***board certified*** oral and maxillofacial surgeon, I have been trained and am fully licensed to perform these surgical services.

While I understand that this is a self-insured plan, I think it is appropriate to point out that section 1861(r) of the Social Security Act contains the provisions of Medicare which prohibit the denial of payment based on the academic degree of the provider performing services. Under Medicare, the definition of physician includes doctor of dental surgery or medicine who is legally authorized to practice medicine in the state in which no functions are performed. I have enclosed a copy of Medicare and Medicaid statutes which contain the definition of physician.

Oral and maxillofacial surgery, as defined by the American Dental Association (ADA), is the specialty of dentistry that includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial regions. This definition builds upon the ADA definition of dentistry, which defines dentistry as including procedures on "the associated structures of the maxillofacial area."

According to both the American Medical Association and the Joint Commission, criteria used for delineating clinical privileges should be objectively applied and relate to an individual's training, competence, experience and judgment. Many state laws also support these criteria in determining practitioner competence. In fact, ***insert state and further details if known and applicable***. If practitioners possess the requisite skills to perform particular procedures, they should be evaluated on this basis and have clinical privileges delineated accordingly. The same principle should be applied when benefit determination for a patient is being decided rather than an apparently arbitrary judgment which reflects no understanding of the accepted scope of practice of an oral and maxillofacial surgeon both in ***insert state*** and nationally.

Employers, insurance carriers, healthcare organizations and credentialing committees often are not familiar with oral and maxillofacial surgery training and scope of practice. The oral and maxillofacial residency programs entail four years of dental school followed by a minimum of 48 months of full-time training in a hospital-based residency. The American Dental Association Commission on Dental Accreditation, which accredits the residency programs, is a nationally recognized accrediting body approved by the U.S. Department of Education and the Liaison Council on Medical Education. The training for oral and maxillofacial surgeons

Employee (Patient) Name
Employee I.D.
Date of Service

includes the following:

1. All residents are required to complete a core surgical year.
2. Oral and maxillofacial surgeons are trained extensively in the management of hard and soft tissue injuries of the face, including facial esthetic/cosmetic surgery, trauma, nasal, orbital, nasoethmoidal, and malar fractures. Repair of associated or independent soft tissue injuries is an important part of this training, as is the thorough understanding of the wound healing process and contracture of wounds. Rotations to the surgery and medicine services provide additional background.
3. The oral and maxillofacial surgery training standards clearly identify training in reconstructive surgery, including bone and soft tissue grafting, involvement in comprehensive case management, management of continuity defects, facial cleft repair, and craniofacial surgery.
4. Oral and maxillofacial surgeons are required to be trained in the harvesting of bone and soft tissue grafts.
5. Oral and maxillofacial surgeons complete training in independent maxillofacial esthetic procedures including malar augmentation, genioplasty, liposuction and a variety of "lifting" procedures, including cervicofacial rhytidectomy, rhinoplasty, blepharoplasties, scar reconstructions, dermabrasions, and laser. Autologous procedures require obtaining grafts, fat or other tissues from the patient's body to complete some of the esthetic surgery that the oral and maxillofacial surgeon is trained to perform.

Insurance plans, including ***insert name of plan***, should not base reimbursement simply on the degree of the provider. Rather, plans should determine scope of practice-related reimbursement policies on meaningful, objective standards, including Joint Commission criteria. Those standards recognize that a provider's scope of practice must be determined on multiple criteria, including professional education, training, competence, and experience.

Enclosed are the following documents that substantiate the training that oral and maxillofacial surgeons receive and contain information that might broaden one's knowledge of this specialty:

- Commission on Dental Accreditation *Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery*
- *AAOMS/ABOMS Statement on the Training and Practice of Oral and Maxillofacial Surgery*
- *Comparison of OMS Education and Training to Medical Specialties*
- *Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParCare 2012)*

I welcome the opportunity to discuss these details further, including the reasons why I believe an appeal is necessary. May I suggest that an external review be performed by a practicing oral and maxillofacial surgeon, who is equally trained and competent and is familiar with the current treatment protocol. On behalf of ***insert patient name,*** thank you for your anticipated cooperation and review. Please do not hesitate to contact me with any questions or concerns you may have.

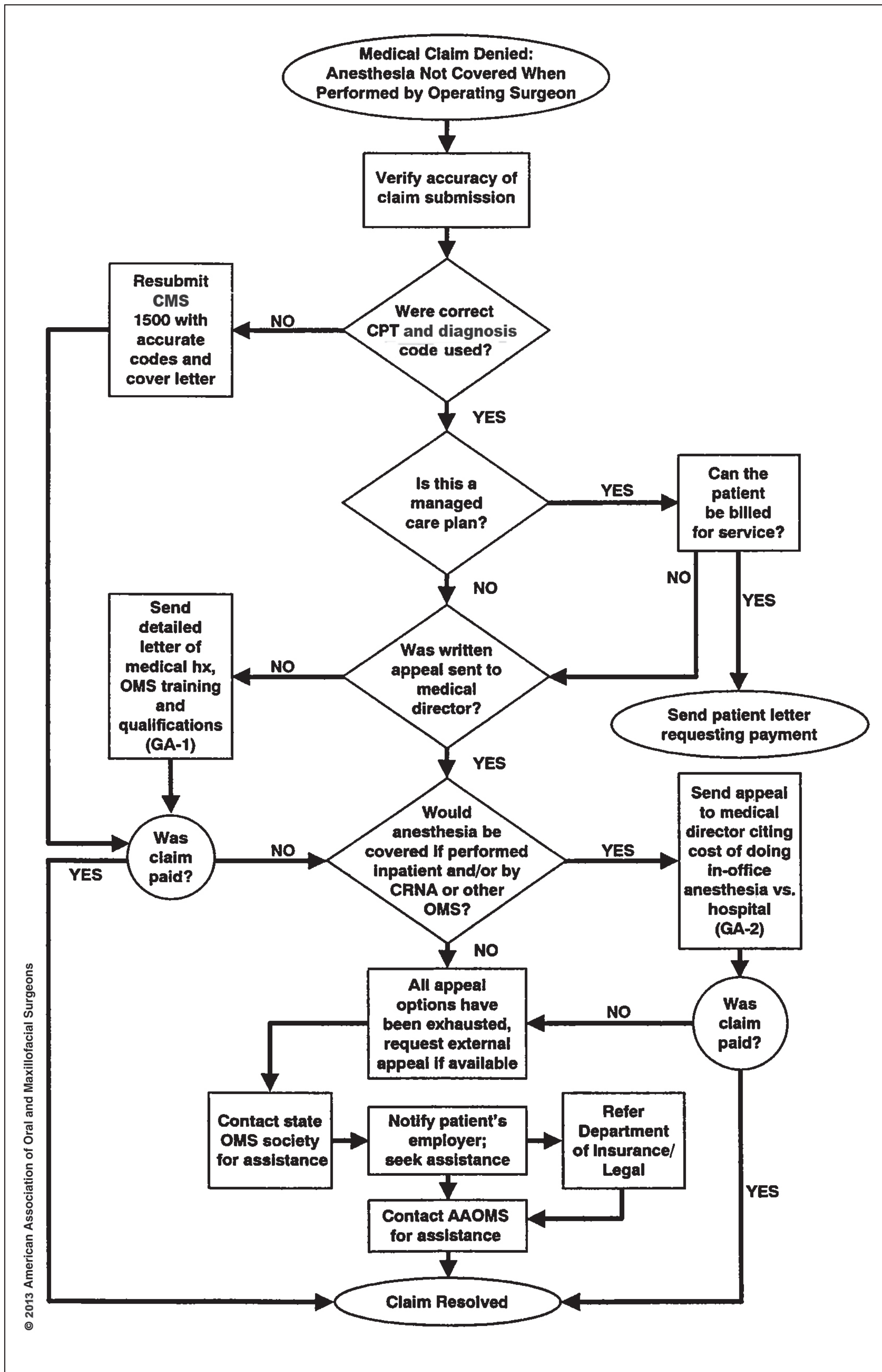
Sincerely,

OMS Name and Degree

cc: Patient/Guarantor
Patient/Guarantor Employer
State OMS Society President
AAOMS President
AAOMS Reimbursement Manager

FLOW CHART

ANESTHESIA BY SURGEON



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SAMPLE APPEAL LETTER
ANESTHESIA BY SURGEON (GA-1)

Date

Medical Director Name and Title
Insurance Carrier
Carrier Address

RE: ***Patient Name***
Patient I.D.
Date of Service

Dear Dr. ***insert Medical Director Last Name:***

Please allow this letter to serve as written notification that I am appealing a recent benefit determination denying anesthesia benefits for my patient, ***insert patient name***. The explanation of benefits states ***insert language from EOB. Insert patient's name***, is a ***insert patient's age and sex*** with ***enter any significant health information (if applicable)***, who presented for ***insert procedure*** for ***insert diagnosis*** on ***insert date*** at ***insert location*** under ***insert type of anesthesia performed.*** While I am certain that you understand the specialty training that is involved and the licensing requirements needed to administer anesthesia, perhaps you are not aware of the significant cost savings associated with the operating surgeon's provision of this service.

Because of our unique training and education, oral and maxillofacial surgeons are licensed to administer general anesthesia in our offices. This enables us to perform complicated surgical procedures in the office which would otherwise have to be provided in a hospital or ambulatory surgical center with the use of an anesthesiologist or CRNA and at a much greater cost to the insurance carrier. Other carriers have reconsidered their policy of denying payment for anesthesia performed by the OMS operating surgeon, as it is much more cost effective for the oral and maxillofacial surgeon to provide the needed service.

Patient pain management is an integral part of the quality care given by healthcare providers. I am sure that your organization prides itself on contracting with providers who have their patients' comfort and quality of care as their foremost concern. Your current policy forces us to revert to more costly alternative sources for anesthesia delivery, not to mention the added inconvenience to the patient.

I ask that you reconsider your policy regarding payment for the anesthesia provided to ***insert patient's name***. I would be happy to discuss this issue further with you.

Sincerely,

OMS Name and Degree

cc: ***Patient/Guarantor***

SAMPLE APPEAL LETTER

ANESTHESIA BY SURGEON (GA-2)

Date

Medical Director Name and Title
Insurance Carrier
Carrier Address

RE: ***Patient Name***
Patient I.D.
Date of Service

Dear Dr. ***insert Medical Director Last Name:***

I recently received a denial for the administration of general anesthesia for my patient, your insured ***insert patient name***. When we attempted to appeal this denial, we were notified of significant changes within your organization relating to anesthesia reimbursement. It is our understanding that the ***insert insurance carrier name*** plan(s) will no longer provide payment to licensed oral and maxillofacial surgeons for the administration of anesthesia when delivered by the operating surgeon. If, in fact, this is the case, I would like to request additional information, specifically as this policy relates to the various plans offered by ***insert insurance carrier name***. Additionally, I would like to know if this applies to administration of anesthesia for all outpatient procedures (endoscopy, hysteroscopy, etc.) by all providers or is this policy specific to oral and maxillofacial surgeons?

The significant cost increase and the lack of discernable increase in quality of patient care associated with disallowing my provision of outpatient anesthesia is of great concern to me. High quality care combined with cost- containment has been, and will continue to be, an important part of how my oral and maxillofacial surgery office is managed. Disallowing coverage of anesthesia when administered by surgeons in the outpatient environment will escalate the cost of procedures by thousands of dollars. The cost of providing anesthesia in the office is substantially lower than that of the alternatives, including hospital operating room, on-site anesthesiology services and day surgery centers. More specifically, the requirements for delivering anesthesia in the aforementioned ways may include expensive pre-surgical testing, additional anesthesia fees, billable postoperative monitoring and operating room costs and supplies. Consideration must also be given to the delivery of anesthesia by a second oral and maxillofacial surgeon. Will the reimbursement to the second surgeon (if available) be equal to that of an anesthesiologist?

More importantly, consideration must be given to patient care. The stress and anxiety often associated with surgery itself will only be magnified by having to admit the patient into the hospital environment or day surgery center.

While changes within the healthcare field are constant and often understandable, this one is not. As mentioned, I would like to learn more details regarding this policy, including what specialties are impacted, how the providers were notified, and which participating providers have had their contracts updated ***(if applicable)***. Finally, I would ask that since the guidelines for administering anesthesia by an operating surgeon were recently changed, why were they changed, and what constituted the change?

Patient Name
Patient I.D.
Date of Service

I would like to believe that an amicable resolution can be achieved. If this is indeed a national policy, covering all ***(insert name of insurance carrier)*** healthcare plans, I will continue my quest at that level as well by involving both our state and national specialty society organizations. I look forward to a written response from you and thank you in advance for your attention to this very important issue.

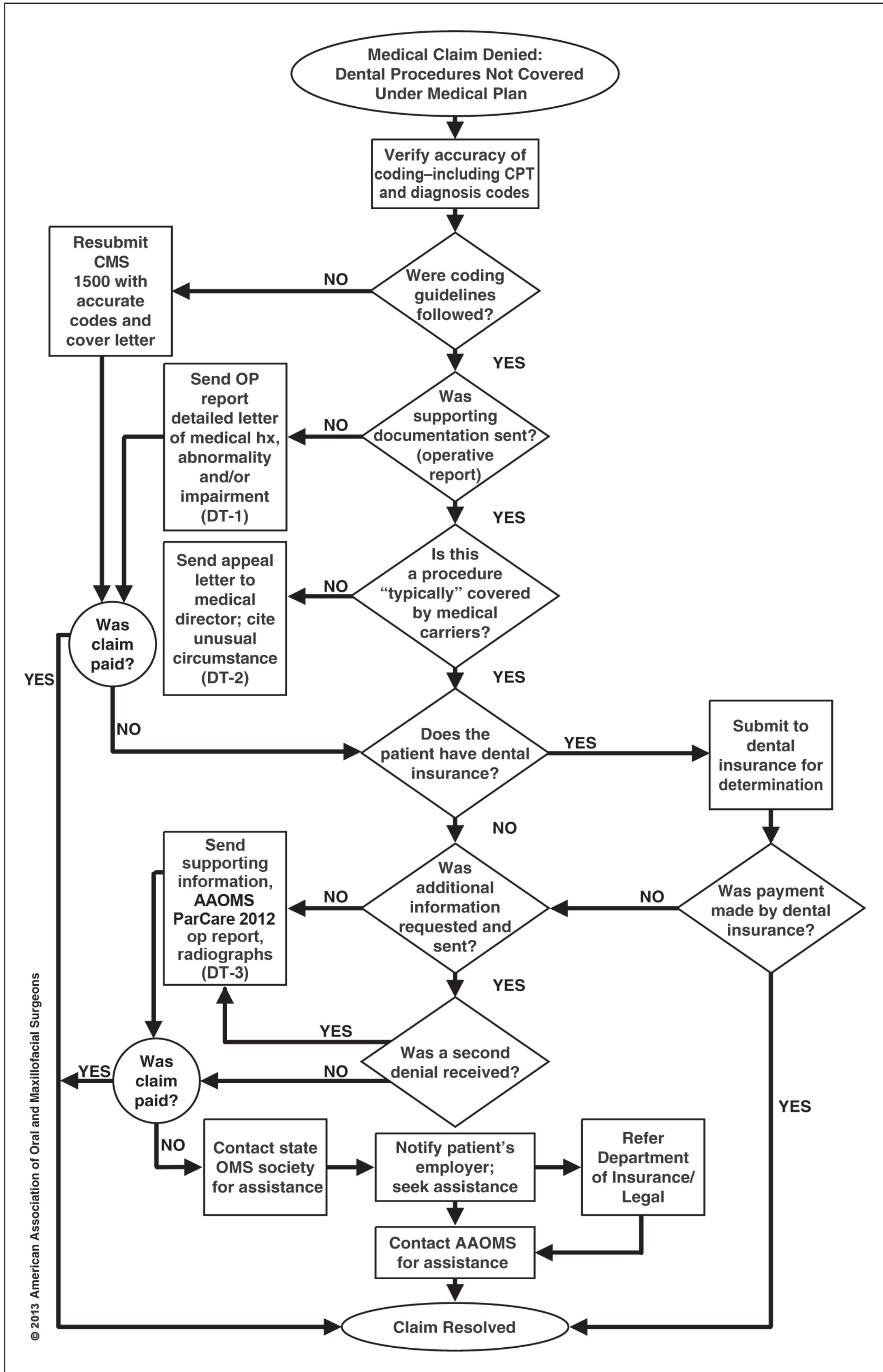
Sincerely,

OMS Name and Degree

cc: Patient/Guarantor
Patient/Guarantor Employer
Human Resources Administrator
State OMS Society
AAOMS District Trustee
AAOMS Reimbursement Manager

FLOW CHART

DENTAL SERVICES NOT COVERED UNDER MEDICAL PLAN



SAMPLE APPEAL LETTER

DENTAL SERVICES NOT COVERED UNDER MEDICAL PLAN (DT-1)

Date

Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

To Whom It May Concern:

I would like to appeal a denial for services rendered to my patient, your insured ***insert patient name***. The explanation of benefits indicates that this procedure has been determined to be "dental" in nature and therefore not covered under the medical plan. This is not correct. ***Insert patient name*** presented with a chief complaint of ***insert details regarding patient's chief complaint and any past treatment***.

Based on the signs and symptoms with which this patient presented, I elected to perform a clinical examination which revealed ***insert clinical findings***. It was also mutually decided that ***insert any diagnostic radiographs and/or tests*** be performed and the results revealed ***insert results and diagnosis.*** As is apparent from this information, the procedures performed were in no way "dental" in nature and should not be denied.

I am enclosing an ***insert any operative report, clinical and/or diagnostic test results*** for review by your professional oral and maxillofacial surgery consultant. I would appreciate a written response and the reprocessing of this claim for reimbursement under this patient's medical benefit policy. Please do not hesitate to contact me should you require any further information.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor

4/13

SAMPLE APPEAL LETTER
DENTAL SERVICES NOT COVERED UNDER MEDICAL PLAN (DT-2)

Date

Medical Director Name and Title
Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

Dear Dr. ***insert Medical Director Name:***

Please allow this letter to serve as a written request for an appeal of denied services rendered to my patient, your insured ***insert patient name***. The explanation of benefits indicates that this procedure, ***insert procedure*** has been determined to be "dental" in nature and therefore not covered under the medical plan. This, in fact, is not correct and the appropriate CPT and diagnosis codes were submitted for the reporting of these services.

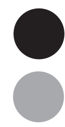
Insert patient name presented with a chief complaint of ***insert details regarding patient's chief complaint and any past treatment***. Based on the unusual signs and symptoms with which this patient presented, I elected to perform a clinical examination which revealed ***insert clinical findings***. It was also mutually decided that ***insert any diagnostic radiographs and/or tests*** be performed and the results revealed ***insert results and diagnosis***. As is apparent from this information, the procedures performed were in no way "dental" in nature and should not be denied. Furthermore, the patient has previously undergone ***insert any past medical treatment rendered, if applicable*** or ***insert any current condition the patient is currently being treated for (cancer, diabetes, kidney disease etc.)***

I am enclosing an ***insert any operative report, clinical and/or diagnostic test results*** for review by your professional oral and maxillofacial surgery consultant. I would appreciate a written response and the reprocessing of this claim for reimbursement under the patient's medical benefit policy. Please do not hesitate to contact me should you require any further information.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor



SAMPLE APPEAL LETTER
DENTAL SERVICES NOT COVERED UNDER MEDICAL PLAN (DT-3)

Date

Medical Director Name and Title
Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

Dear Dr. ***insert Medical Director Name:***

Please allow this letter to serve as a written request for an external and/or third party review of denied services rendered to my patient, your insured ***insert patient name***. The explanation of benefits indicates that this procedure, ***insert procedure*** has been determined to be "dental" in nature and therefore is not covered under the medical plan. This, in fact, is not correct and the appropriate CPT and diagnosis codes were submitted for the reporting of these services.

Insert patient name presented with a chief complaint of ***insert details regarding patient's chief complaint and any past treatment***. Based on the signs and symptoms with which this patient presented, I elected to perform a clinical examination which revealed ***insert clinical findings***. It was also mutually decided that ***insert any diagnostic radiographs and/or tests*** be performed and the results revealed ***insert results and diagnosis.*** As is apparent from this information, the procedures performed were in no way "dental" in nature and should not be denied. Furthermore, the patient has previously undergone ***insert any past medical treatment rendered, if applicable*** or ***insert any current condition the patient is currently being treated for (cancer, diabetes, kidney disease etc.)***

I am enclosing an ***insert any operative report, clinical and/or diagnostic test results*** for review by your professional oral and maxillofacial surgery consultant. I am also enclosing the most recent publication from the American Association of Oral and Maxillofacial Surgeons (AAOMS) regarding the treatment of this condition. Enclosed you will find ***insert chapter name*** from the *AAOMS Parameters of Care (AAOMS ParCare 2012)* which details the appropriate treatment pathway as well as the indications for treatment. I am also enclosing ***insert any additional documentation (AAOMS Clinical Condition Statement, articles, professional referrals, etc.)***

I believe this information will be beneficial to the individual who performs this independent review. I will await a written response and the reprocessing of this claim for reimbursement under this patient's medical benefit policy. Please do not hesitate to contact me should you require any further information.

Sincerely,

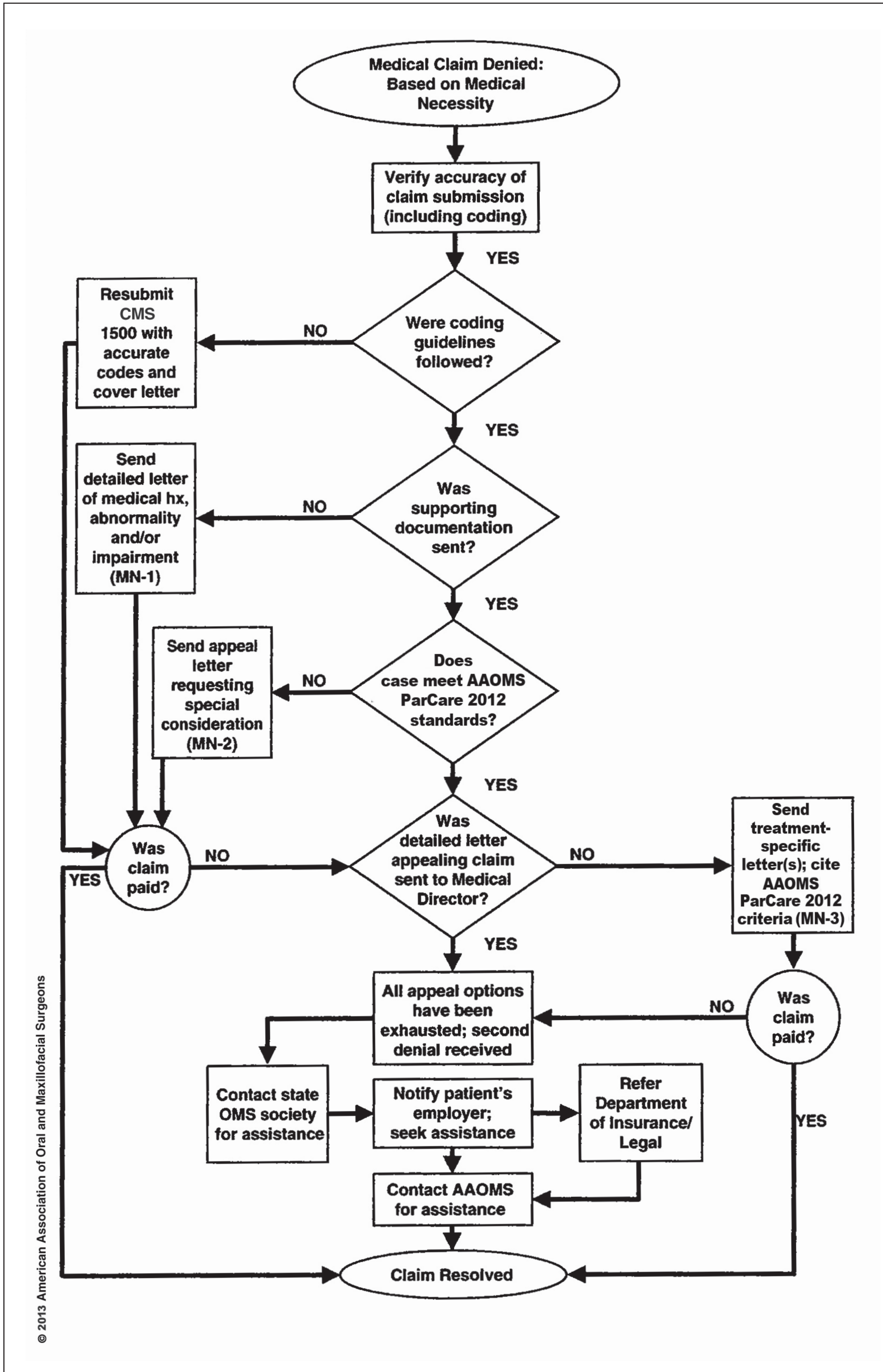
OMS Name and Degree

cc: Patient/Guarantor

4/13

FLOW CHART

MEDICAL NECESSITY



SAMPLE APPEAL LETTER

MEDICAL NECESSITY (MN-1)

Date

Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

To Whom it May Concern:

I am requesting reconsideration of services denied for my patient, your insured, ***insert patient's name***, for the aforementioned date of service. The written correspondence indicates the procedure was denied because it was not medically necessary, and I quote ***insert exact wording from EOB. Insert patient name***, underwent a ***insert billed services here*** for the ***insert reason or diagnosis here***.

I believe that this procedure is medically necessary and, in fact, is not excluded from the benefit policy. I would like to offer the following information and ask that the claim be reconsidered and payment made accordingly. ***Insert patient name*** presented with a chief complaint of ***insert details here***, and a history of ***insert history here followed by any other treatment received or opinions sought relating to this chief complaint***. Upon clinical examination it was evident that ***insert clinical findings here. Be sure to indicate any unusual findings and/or outcomes.*** Enclosed is ***insert any enclosures, such as an operative report, photos, and radiograph that would support your treatment***.

Please do not hesitate to contact me if you have any questions or concerns regarding the services provided to ***insert patient name***. On behalf of both the patient and myself, we thank you for reconsidering this denial and look forward to receiving payment for these services.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor

SAMPLE APPEAL LETTER
MEDICAL NECESSITY (MN-2)

Date

Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

To Whom it May Concern:

Please allow this letter to serve as written notice that I would like to appeal a claim denial for my patient, ***insert patient name***, for the aforementioned date of service. ***Insert patient name*** was originally seen by me on ***insert original office visit date*** and had a chief complaint of ***insert details regarding patient's chief complaint and any past treatment***. Based on the signs and symptoms with which this patient presented, I elected to perform a clinical examination which revealed ***insert clinical findings***. It was also mutually decided that ***insert any diagnostic radiographs and/or tests*** be performed and the results indicate ***insert results***.

Based on ***insert patient's name*** chief complaint, clinical signs and symptoms, as well as the diagnostic tests, ***insert treatment was performed***. The treatment performed was necessary due to the patient's extenuating signs and symptoms. These services in no way should be considered "not medically necessary," as they were undertaken to eliminate and/or improve the ***insert details re: functional/pathologic***. Furthermore, Medicare has defined medically necessary services to be services which are safe and effective; are consistent with the symptoms or diagnosis of the illness or injury; are necessary and consistent with generally accepted medical standards; are furnished at the most appropriate, safe and effective level; and are not furnished primarily for the convenience of the patient, the attending physician or other physician or supplier. I am confident that once you have reviewed the information contained in this letter, as well as the enclosed ***insert clinical test results, radiograph results and any operative report***, you will determine that the services provided were in fact medically necessary and appropriate.

Thank you in advance for your attention and reconsideration of benefits for this medically necessary service. Please do not hesitate to contact me if you have any questions or concerns.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor

SAMPLE APPEAL LETTER

MEDICAL NECESSITY (MN-3)

Date

Medical Director Name and Title
Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

Dear Dr. ***insert Medical Director Last Name***:

Please allow this letter to serve as written notice that I would like to appeal a claim denial for my patient ***insert patient name*** for the aforementioned date of service. ***Insert patient name*** was originally seen by me on ***insert original office visit date*** and presented with a chief complaint of ***insert details regarding patient's chief complaint and any past treatment***. Based on the signs and symptoms exhibited by this patient, I elected to perform a clinical examination which revealed ***insert clinical findings***. It was also mutually decided that ***insert any diagnostic radiographs and/or tests*** be performed and the results indicate ***insert results***.

Based on ***insert patient's name*** chief complaint, clinical signs and symptoms as well as the diagnostic tests, I elected to perform ***insert treatment***. In no way should these services be considered "not medically necessary," as they were rendered to eliminate and/or improve the ***insert details re: functional/pathologic***. The treatment that has been rendered was medically necessary and appropriate. I am including for your review the American Association of Oral and Maxillofacial Surgeons' position regarding the treatment for this condition as published in the *AAOMS Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParCare 2012).*

I would also like to mention that Medicare has defined "medically necessary" services to be services that are safe and effective; are consistent with the symptoms or diagnosis of the illness or injury; are necessary and consistent with generally accepted medical standards; services are furnished at the most appropriate, safe and effective level; and are not furnished primarily for the convenience of the patient, the attending physician or other physician or supplier. I am confident that once you have reviewed the information contained in this letter as well as the enclosed ***insert clinical test results, radiograph results and any operative report*** you will find that the treatment rendered in fact was medically necessary.

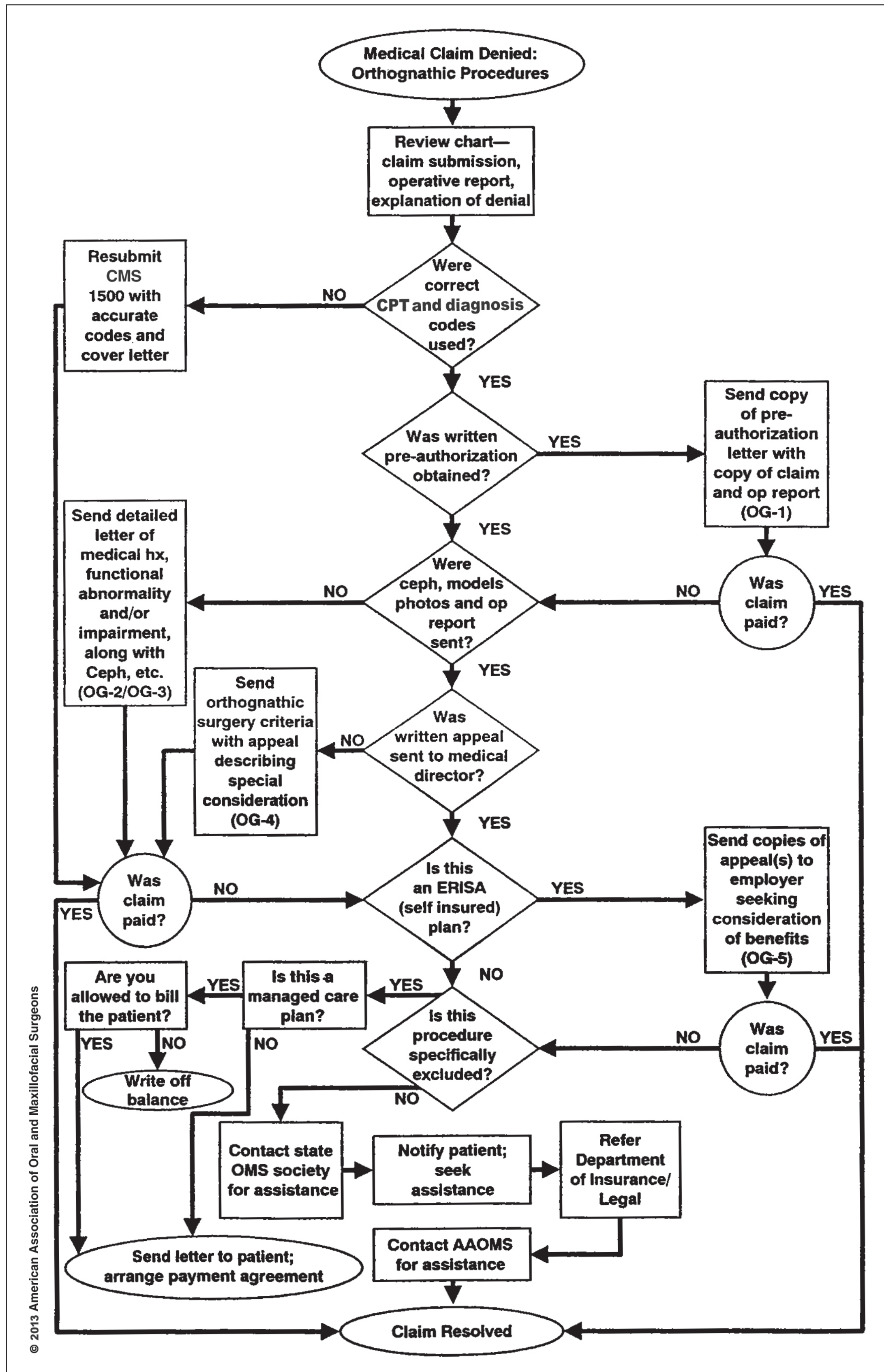
On behalf of ***insert patient name,*** thank you in advance for your attention and reconsideration of benefits for these services. Please do not hesitate to contact me if you have any additional questions or concerns.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor
State OMS Society
AAOMS Reimbursement Manager

FLOW CHART
ORTHOGNATHIC PROCEDURES



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SAMPLE APPEAL LETTER
ORTHOGNATHIC PROCEDURES (OG-1)

Date

Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

To Whom it May Concern:

Please find enclosed a copy of a predetermination for services that were recently performed and subsequently denied. While I understand that a predetermination is not a guarantee of benefits, I believe that this was an administrative error and am requesting these charges be revisited and payment made. For your convenience I am also enclosing a copy of the original claim form, operative report, predetermination letter and explanation of benefits for your review.

On behalf of ***insert patient name*** and myself, thank you in advance for your assistance and timely response to this inquiry.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor

SAMPLE APPEAL LETTER

ORTHOGNATHIC PROCEDURES (OG-2)

Date

Insurance Carrier
Carrier Address

RE: ***Patient Name***
Patient I.D.
Date of Service

To Whom it May Concern:

Please allow this letter to serve as a written appeal for benefits denied my patient, your insured, ***insert patient name. Mr./Ms. insert last name*** is a ***insert age and sex*** who was referred to our office for surgical correction of ***his/her*** facial skeletal deformity. Your denial states, ***insert wording from EOB such as, … provides coverage for services and supplies which are medically necessary.*** Orthognathic surgery is medically necessary and appropriate when the condition(s) described below cannot be corrected by non-surgical means. The ***insert clinical discrepancy*** that ***insert patient name*** exhibits is significantly greater than the standard norm.

Insert patient name originally presented to me with a chief complaint(s) and signs or symptoms that included: ***insert specific details, (such as any that apply diminished bite forces; inability to "tear"and chew food; difficulty with speech articulation; inability to close lips completely; dry mouth; sleep disturbance including mouth breathing, as well as psychological implications from appearance, eating and speaking in front of peers as well as strangers).***

Tailor the letter dependent on the patient's symptoms, for example: Physical characteristics are one of the most important determinants of self-esteem, behavior, and productive personal interactions. In addition to measurable improvements in masticatory function, studies demonstrate the beneficial effects on patients' self-image after surgical correction of facial skeletal deformities, including the ability to speak in public, eat without fear and/or the proper articulation of words. Studies demonstrate that altered speech may be associated with facial skeletal deformities, the most common impairment of which is distortion within the sibilant sound class.

Your denial letter goes on to state that ***insert specifics such as, benefits are only available for those procedures which provide meaningful improvement when addressing a significant disability. Insert patient name***, in fact, considers the aforementioned signs and symptoms a disability in all senses of the word, and I concur. Disability is defined as "signifying loss of function." This patient clearly demonstrates a significant disability.

In conclusion, it is essential that this case be reviewed by an oral and maxillofacial surgeon who is experienced and competent in the contemporary management of patients with these deformities. I look forward to your response and written approval of these medically necessary surgeries. I will continue to appeal, if necessary, on behalf of this medically compromised patient ***and/or his/her parents, if applicable.***

Sincerely,

OMS Name and Degree

c***c:*** ***Patient/Guarantor***

SAMPLE APPEAL LETTER

ORTHOGNATHIC PROCEDURES (OG-3)

Date

Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

To Whom it May Concern:

Please allow this letter to serve as a written appeal for benefits denied my patient, your insured, ***insert patient name. Mr./Ms. insert last name*** is a ***insert age and sex*** who was referred to our office for surgical correction of ***his/her*** facial skeletal deformity. Your denial states, ***"insert wording from EOB such as, … provides coverage for services and supplies which are medically necessary."*** Orthognathic surgery is medically necessary and appropriate when the condition(s) described below cannot be corrected by non-surgical means. The ***insert clinical discrepancy*** that ***insert patient name*** exhibits is significantly greater than the standard norm.

Insert patient name originally presented to me with a chief complaint(s) and signs or symptoms that included: ***insert specific details, (such as any that apply diminished bite forces; inability to "tear"and chew food; difficulty with speech articulation; inability to close lips completely; dry mouth; sleep disturbance including mouth breathing as well as psychological implications from her appearance, eating and speaking in front of peers as well as strangers).***

Tailor the letter dependent on the patient's symptoms, for example: Physical characteristics are one of the most important determinants of self-esteem, behavior, and productive personal interactions. In addition to measurable improvements in masticatory function, studies demonstrate the beneficial effects on patients' self image after surgical correction of facial skeletal deformities, including the ability to speak in public, eat without fear and/or the proper articulation of words. Studies demonstrate that altered speech may be associated with facial skeletal deformities, the most common impairment of which is distortion within the sibilant sound class.

Your denial letter goes on to state that ***"insert specifics such as, benefits are only available for those procedures which provide meaningful improvement when addressing a significant disability." Insert patient name***, in fact, considers the aforementioned signs and symptoms a disability in all senses of the word, and I concur. Disability is defined as "signifying loss of function." This patient clearly demonstrates a significant disability.

I am enclosing two documents published by the American Association of Oral and Maxillofacial Surgeons (AAOMS) titled *Recommended Criteria for Orthognathic Surgery*, and *AAOMS Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParCare 2012)*, both of which have established standards and criteria which assess the clinical indications for orthognathic surgery.

4/13

Page Two (OG-3)

Patient Name
Patient I.D.
Date of Service

In conclusion, it is essential that this case be reviewed by an oral and maxillofacial surgeon who is experienced and competent in the contemporary management of patients with these deformities. I look forward to your response and written approval of these medically necessary surgeries. I will continue to appeal, if necessary, on behalf of this medically compromised patient ***and/or his/her parents, if applicable.***

Sincerely,

OMS Name and Degree

cc: ***Patient/Guarantor***
Patient/Guarantor Employer
Human Resources Manager
State OMS Society
AAOMS Reimbursement Manager

SAMPLE APPEAL LETTER

ORTHOGNATHIC PROCEDURES (OG-4)

Date

Medical Director Name and Title
Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

Dear Dr. ***insert Medical Director Name:***

Conditions requiring orthognathic surgical intervention can be categorized as aberrations in bone growth characterized by excessive or deficient developments, absence of growth, and resulting deformity of the mandible, maxilla or mid-face portions of the skeleton of the head. These morphological discrepancies can be of congenital, developmental or traumatically induced etiology. The malrelationships of facial skeletal bones, including malocclusions of the jaws and temporomandibular joint derangements, are the result of these growth anomalies and not the primary disease entities. Stability of the adjacent joint function can be improved through orthognathic correction, although prevention of future temporomandibular joint pathology is not an indication for surgery. Orthognathic patients are frequently referred from orthodontists who have already attended the dental malocclusions and have identified a skeletal deformity requiring the services of the oral and maxillofacial surgeon. Please refer to the enclosed copy of the original letter for authorization which describes the problems ***insert patient's name*** has as a result of the stated facial skeletal deformity.

The skeletal deformity can be graphically depicted through cephalometric analysis and expressed as a number representing the degree of deviation from standard norms. While this figure would not necessarily describe the severity of dysfunction or the extent of disfigurement actually experienced by the patient, such predictive tests are extremely valuable to the surgeon in preparing a blueprint for performance of the procedure and visualizing an expected outcome for the surgery. Moreover, based on the *AAOMS Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region*, the patient exhibits ***insert stated impairment/dysfunction here***.

Medical necessity is established by the diagnosis of a musculoskeletal deformity, which is abnormal and constitutes a medical condition for which surgical correction is indicated. The diagnosis of this procedure cannot be considered dental nor cosmetic since the purpose of the surgery is to correct an abnormal skeletal deformity towards normal. By definition, this defines the procedure as reconstructive in nature. Although improved facial symmetry usually follows the correction of a skeletal deformity, it is a secondary result and is not the essential purpose of the orthognathic surgery, which is to improve function. In fact, my professional association, the American Association of Oral and Maxillofacial Surgeons (AAOMS), has established standards for clinical indications of orthognathic surgery as outlined in the *AAOMS Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParCare 2012).*

In light of this information, I am requesting reconsideration of the claim denial be made by a qualified oral and maxillofacial surgeon consultant. I have enclosed the insurance consultant standards set by my professional association for your information. Should you wish to discuss this further, please feel free to give me a call at ***insert telephone number***.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor

SAMPLE APPEAL LETTER
ERISA PLAN ORTHOGNATHIC SURGERY (OG-5)

Date

Employer Name and Address
ATTN: Human Resources Manager
Address

RE: ***Employee (Patient) Name***
Employee I.D.
Date of Service

Dear ***insert Human Resources Manager Name:***

I am writing on behalf of, and with authorization from, ***insert patient name*** to request your assistance with a medical benefit denial. Enclosed is the correspondence that has recently taken place between my office and ***insert third party administrator name***. While I understand that as an ERISA plan you are not bound by state law, we are asking that special consideration be given to this patient and approval granted for the necessary treatment.

I welcome the opportunity to discuss the details further including the reasons why I believe an appeal is necessary. May I suggest that an external review be performed by a practicing oral and maxillofacial surgeon, who is equally trained and competent and is familiar with the current treatment protocol? On behalf of ***insert patient name***, thank you for your anticipated cooperation and review. Please do not hesitate to contact me with any questions or concerns you may have.

Sincerely,

OMS Name and Degree

cc: ***Patient/Guarantor***
Third Party Administrator
State OMS Society
AAOMS Reimbursement Manager
State Department of Labor

SAMPLE APPEAL LETTER

PREDETERMINATION OF MEDICAL BENEFITS

Date

Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

To Whom it May Concern:

As previously requested, I am asking for reconsideration of benefits for ***insert patient name***. ***Mr./Ms. insert patient name*** has been more than patient waiting for the appeals process and pre-determination of insurance coverage. While it is my understanding that ***insert insurance company*** name does not pay for cosmetic procedures, I do believe that surgical benefits for functional abnormalities and/or impairment are considered medically necessary, and therefore a covered benefit. The proposed treatment is recognized as an acceptable treatment modality for this condition and should be reimbursed accordingly.

The proposed procedure ***insert procedure to be performed and any specific details regarding this patient.*** The patient has expressed his desire to seek treatment that is medically appropriate and therefore I have suggested the aforementioned treatment based on the chief complaint ***insert chief complaint(s)*** and clinical examination including ***insert results***.

Insert patient name underwent a consultation ***insert date and type of consultation or diagnostic testing*** that revealed the patient ***insert any relative findings to support the proposed treatment***. ***Insert patient name*** has also tried several medications including ***list medications if appropriate and relative***. The various medication therapies have proven to only ***insert results such as, (slightly improve his symptoms, offering little if any improvement, or is a narcotic and cannot be taken routinely)***.

In light of his/her chief complaint, ***insert patient name***, has been an extremely compliant patient and has tried all alternative methods while awaiting your approval for the proposed surgery. If there is an alternative treatment or procedure for which that ***insert insurance company name*** is willing to pay I would like the opportunity to discuss this with my patient.

I appreciate your reconsideration of benefits for ***insert patient name***. We look forward to receiving authorization for this proposed surgical treatment. If in fact, you determine that this is an "excluded" benefit or a "non-covered" procedure I would like this information specifically stated and copied from the benefits package. Thank you in advance for your attention to this pre-authorization.

Sincerely,

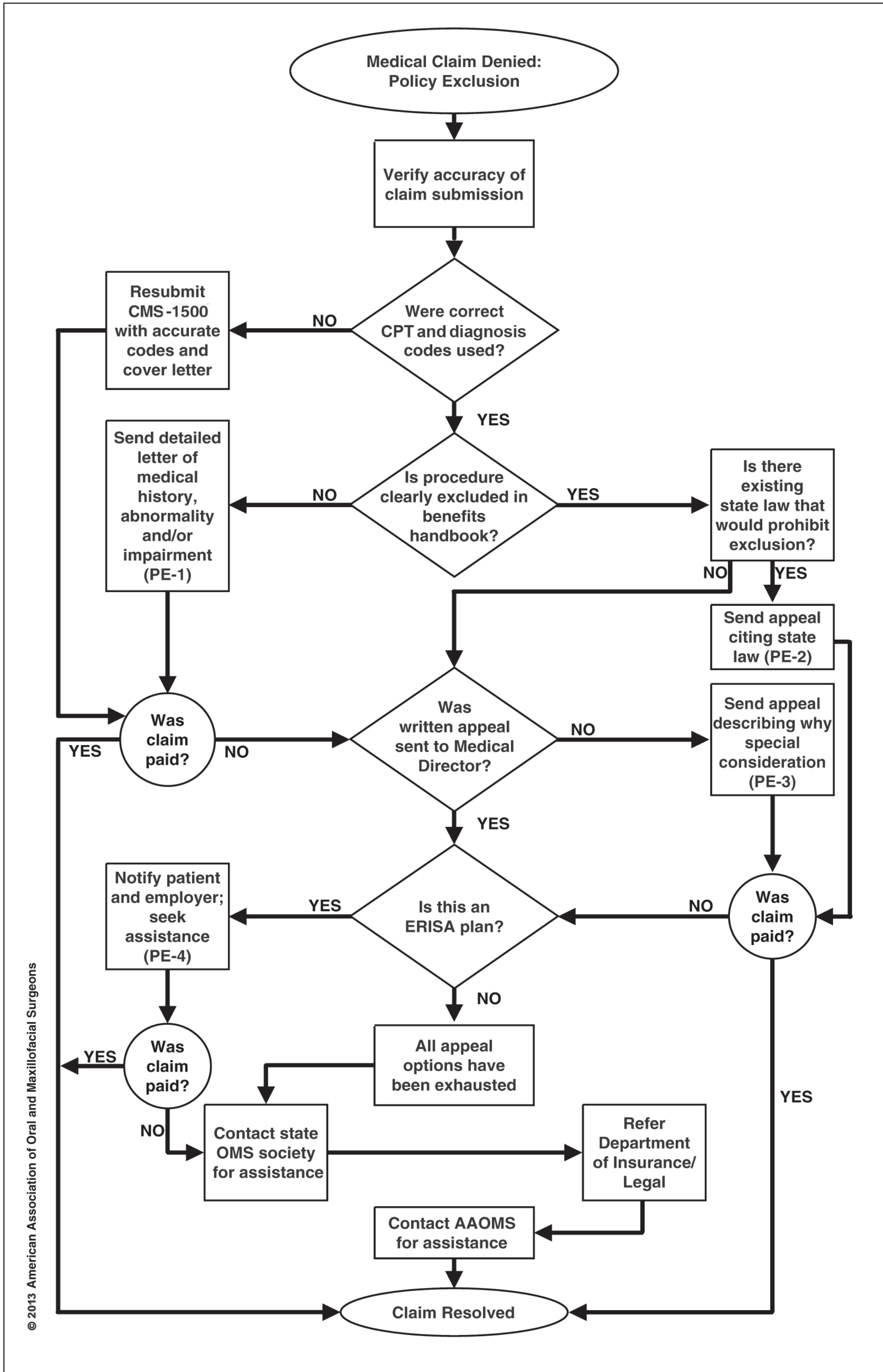
OMS Name and Degree

cc: Patient/Guarantor

4/13

FLOW CHART

POLICY EXCLUSION



SAMPLE APPEAL LETTER
POLICY EXCLUSION (PE-1)

Date

Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

To Whom it May Concern:

I am requesting reconsideration of services denied for my patient, your insured, ***insert patient' s name***, for the aforementioned date of service. The written correspondence indicates the procedure was denied because of a policy exclusion. ***Insert patient name***, underwent a ***insert billed services here*** for the ***insert reason or diagnosis here***.

After reviewing the written medical policy provided to my office by the patient, we do not believe that this procedure is excluded. I would like to offer the following information and ask that the claim be reconsidered and payment made accordingly. ***Insert patient name*** presented with a chief complaint of ***insert details here***, and a history of ***insert history here followed by any other treatment received or opinions sought relating to this chief complaint.*** Upon clinical examination it was evident that ***insert clinical findings here***. ***Be sure to indicate any unusual findings and/or outcomes***. Enclosed is ***insert any enclosures, such as an operative report, photos, radiograph, etc. that would support your treatment***.

Please do not hesitate to contact me if you have any questions or concerns regarding the services provided to ***insert patient name***. On behalf of both the patient and myself we thank you for reconsidering this denial and look forward to receiving payment for these services.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor

SAMPLE APPEAL LETTER

POLICY EXCLUSION (PE-2)

Date

Insurance Carrier
ATTN: Medical Director
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

To Whom it May Concern:

A written denial was received for my patient, ***insert name***, who underwent a ***insert procedure*** for ***insert diagnosis*** on ***insert date***. I am requesting that determination of benefits be reconsidered based on the state law which prohibits exclusion of this procedure or treatment. Specifically, ***insert state name*** has legislation which prohibits third party payers from ***excluding or limiting*** benefits for treatment of ***insert diagnosis and/or condition***.

While I am certain that this was an administrative error, we want to be sure that the information you have is both current and accurate. I am enclosing a copy of ***insert state law and/or regulation*** which clearly cites this information for your records. On behalf of the patient and myself, we thank you for your prompt reversal of this denial and look forward to receiving payment for these services

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor

SAMPLE APPEAL LETTER

POLICY EXCLUSION (PE-3)

Date

Medical Director Name and Title
Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

Dear Dr. ***Medical Director:***

On behalf of my patient, your insured, ***insert patient name***, I am requesting your assistance. A claim for services was submitted and a written denial received from ***insert carrier name*** on ***insert date notified***. Although we have been advocating reimbursement on behalf of this patient our attempts thus far have been unsuccessful. I am confident that once you have reviewed the following information, benefits on behalf of this patient will be allowed.

Insert patient name underwent ***insert procedure*** for i***nsert diagnosis and/or condition***. While this diagnosis may not be typically covered under this plan we are asking for special consideration due to the extenuating circumstances with which this patient has presented. The condition for which this patient presents has, in the past, been treated or consulted by ***insert names of practitioners and their specialties***. I am enclosing a copy of ***insert patient name*** medical record, including ***any written referrals, radiographs, models, photos, studies, exam results, medication history, and/or other pertinent documentation that would support your efforts***.

While we understand that reimbursement may not be typical for this diagnosis, I am confident that once you have had an opportunity to review the enclosed information, benefits will be granted for this medically necessary and indicated procedure. Please do not hesitate to contact me should you have any questions or concerns. On behalf of ***insert patient name***, thank you for the special consideration and benefit allowance.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor
Patient/Guarantor Employer
Human Resources Department

SAMPLE APPEAL LETTER
POLICY EXCLUSION (PE-4)

Date

Employer
ATTN: Human Resources Manager
Employer Address

RE: Employee Name
Patient Name

Dear ***insert Human Resources Manager Name:***

On behalf of my patient, ***insert patient name***, I am requesting that special consideration be given by ***employer name*** for benefits previously denied by ***insert name of third party carrier. Insert patient name*** has provided me with written authorization allowing me to share ***his/her*** necessary health information with you for the purpose of appealing this denial.

Although we have been advocating on behalf of this patient our attempts thus far have been unsuccessful. I am confident that once you have reviewed the following information, benefits on behalf of this patient will be allowed.

Insert patient name underwent ***insert procedure*** for ***insert diagnosis and/or condition***. While this diagnosis may not be typically covered under this plan we are asking for special consideration due to the extenuating circumstances this patient has presented. The condition for which this patient presents has, in the past, been treated with or consulted by ***insert names of practitioners and their specialties***. I am enclosing a copy of ***insert patient name*** medical record, including a***ny written referrals, radiographs, models, photos, studies, exam results, medication history, and/or other pertinent documentation that would support your efforts***.

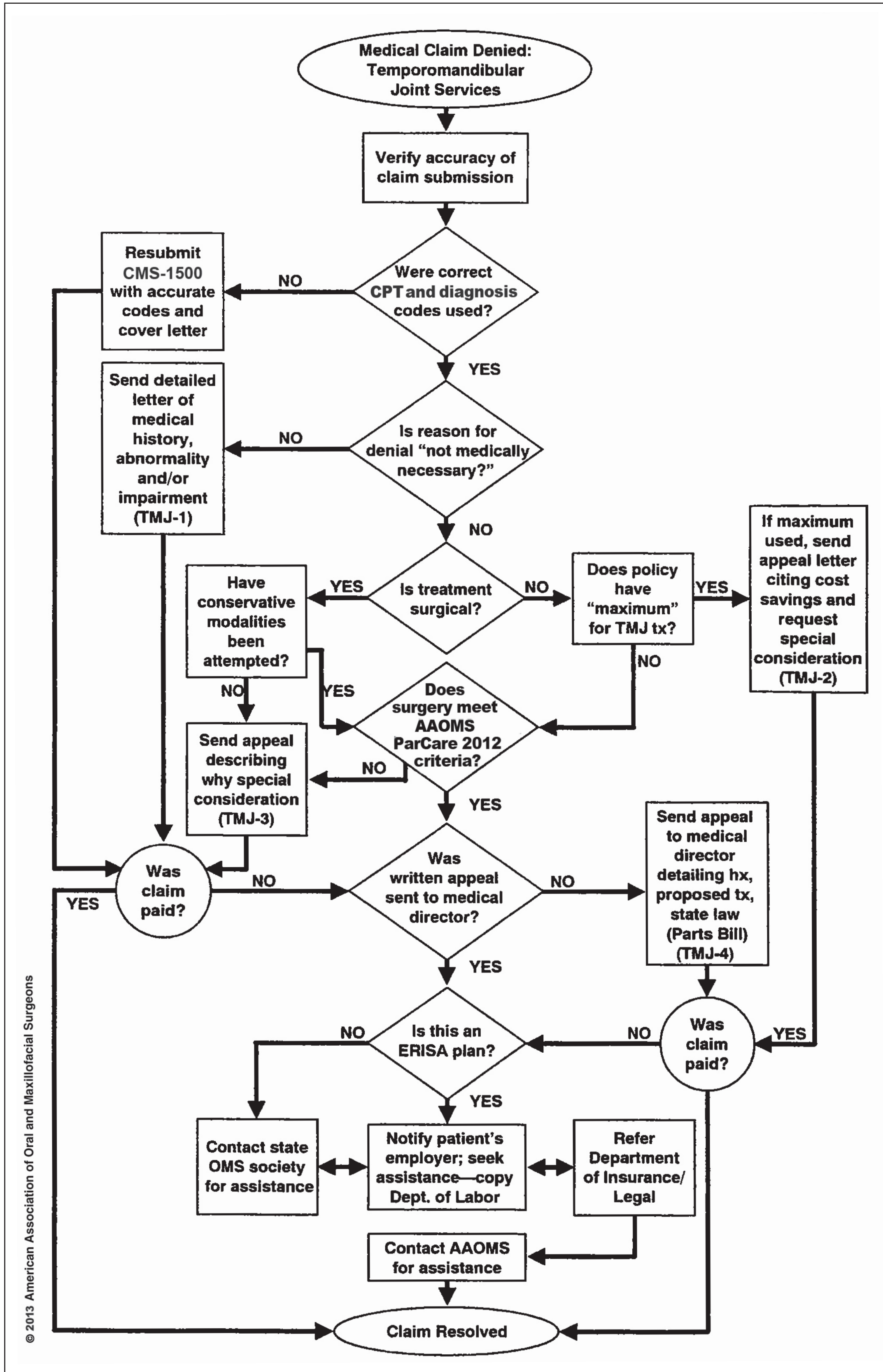
While we understand that reimbursement may not be typical for this diagnosis, I am confident that once you have had an opportunity to review the enclosed information, benefits will be granted for this medically necessary and indicated procedure. Please do not hesitate to contact me should you have any questions or concerns. On behalf of ***insert patient name***, thank you for the special consideration and benefit allowance.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor
Employer Executive
State Labor Board
State OMS Society President
AAOMS President
AAOMS Reimbursement Manager

FLOW CHART
TEMPOROMANDIBULAR JOINT SERVICES



SAMPLE APPEAL LETTER
TEMPOROMANDIBULAR JOINT SERVICES (TMJ-1)

Date

Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

To Whom it May Concern:

Please allow this letter to serve as written notice that I would like to appeal a claim denial for my patient ***insert patient name***, for the aforementioned date of service. ***Insert patient name*** was originally seen by me on ***insert original office visit date*** and presented with a chief complaint of i***nsert details regarding patient's chief complaint and any past treatment***. Based on the signs and symptoms exhibited by this patient I elected to perform a clinical examination which revealed ***insert clinical findings***. It was also mutually decided that ***insert any diagnostic radiographs and/or tests*** be performed and the results indicate ***insert results***.

Based on ***insert patient's name, the diagnostic tests, chief complaint, and clinical signs and symptoms***, I elected to perform ***insert treatment***. In no way should these services be considered "not medically necessary" as they were rendered to eliminate and/or improve the ***insert details re: functional/pathologic impairment***. The treatment that has been rendered was medically necessary and appropriate. The American Association of Oral and Maxillofacial Surgeons' position regarding the treatment for this condition is published in the *AAOMS Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParCare 2012)* and is enclosed for your reference.

I would also like to point out that Medicare has defined "medically necessary" services to be services which are safe and effective; are consistent with the symptoms or diagnosis of the illness or injury; are necessary and consistent with generally accepted medical standards; services are furnished at the most appropriate, safe and effective level; and are not furnished primarily for the convenience of the patient, the attending physician or other physician or supplier. I am confident that once you have reviewed the information contained in this letter, as well as the enclosed ***insert clinical test results, radiograph results and any operative report***, you will find that the treatment rendered in fact was medically necessary.

On behalf of ***insert patient name***, thank you in advance for your attention and reconsideration of benefits for these services. Please do not hesitate to contact me if you have any additional questions or concerns.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor

SAMPLE APPEAL LETTER

TEMPOROMANDIBULAR JOINT SERVICES (TMJ-2)

Date

Medical Director Name and Title
Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

Dear Dr. ***insert Medical Director Name:***

I am writing to request special benefit consideration be given to my patient, your insured ***insert patient name***, for the aforementioned date of service. ***Insert patient name*** was originally seen by me on ***insert original office visit date*** and presented with a chief complaint of ***insert details regarding patient's chief complaint and any past treatment***. Based on the signs and symptoms exhibited by this patient, I elected to perform a clinical examination which revealed ***insert clinical findings***. It was also mutually decided that ***insert any diagnostic radiographs and/or tests*** be performed and the results indicate ***insert results***.

Due to the unusual circumstances with which this patient presented, including ***insert severe or unusual chief complaint, functional impairment, trauma, accident, clinical signs and symptoms as well as the diagnostic test results***, I elected to perform ***insert treatment***.

While I understand that ***insert patient name*** may have reached ***his/her*** annual maximum for non-surgical services relating to the temporomandibular joint, we would like to request special consideration be given in light of the extenuating circumstances surrounding this patient's condition. The alternative treatment would be to surgically correct this deficiency, and although surgery may ultimately be required, we would like the opportunity to exhaust all conservative modalities prior to any invasive treatment. ***Insert patient name*** has indicated that ***he/she*** is unable to afford the treatment due to current ***insert reason, ie, financial hardship***.

On behalf of ***insert patient name***, thank you in advance for your attention and reconsideration of benefits for these services. Please do not hesitate to contact me if you have any additional questions or concerns.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor

SAMPLE APPEAL LETTER

TEMPOROMANDIBULAR JOINT SERVICES (TMJ-3)

Date

Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

To Whom it May Concern:

I am writing to request special benefit consideration be given to my patient, your insured ***insert patient name***, for the aforementioned date of service. ***Insert patient name*** was originally seen by me on ***insert original office visit date*** and presented with a chief complaint of i***nsert details regarding patient's chief complaint and any past treatment***. Based on the signs and symptoms exhibited by this patient, I elected to perform a clinical examination which revealed ***insert clinical findings***. It was also mutually decided that ***insert any diagnostic radiographs and/or tests*** be performed and the results indicate ***insert results***.

Due to the unusual circumstances with which this patient presented, including ***insert severe or unusual chief complaint, functional impairment, trauma, accident, clinical signs and symptoms, as well as the diagnostic test results***, I elected to perform ***insert treatment***. In light of the extenuating circumstances surrounding this patient's condition, the treatment rendered was medically appropriate and necessary. The alternative treatment would be to ***insert alternative treatment if any***, and although that may ultimately be required we would like the opportunity to exhaust all options prior to any extensive invasive treatment.

On behalf of ***insert patient name***, thank you in advance for your attention and reconsideration of benefits for these services. Please do not hesitate to contact me if you have any additional questions or concerns.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor

4/13

SAMPLE APPEAL LETTER

TEMPOROMANDIBULAR JOINT SERVICES (TMJ-4)

Date

Medical Director Name and Title
Insurance Carrier
Carrier Address

RE: Patient Name
Patient I.D.
Date of Service

Dear Dr. ***insert Medical Director Name:***

Please allow this letter to serve as written notification that I would like to appeal benefits that have been denied for my patient, your insured ***insert patient name***, for the aforementioned date of service. ***Insert patient name*** was originally seen by me on ***insert original office visit date*** and presented with a chief complaint of ***insert details regarding patient's chief complaint and any past treatment***. Clinical examination revealed ***insert clinical findings***. It was also mutually decided that ***insert any diagnostic radiographs and/or tests*** be performed and the results indicate ***insert results.***

Due to the extensive conditions with which this patient presented, including ***insert severe or unusual chief complaint, functional impairment, trauma, accident, clinical signs and symptoms, as well as the diagnostic test results***, I elected to perform ***insert treatment***. In light of the extenuating circumstances surrounding this patient's condition the treatment rendered was medically appropriate and necessary. The alternative treatment would be to ***insert alternative treatment if any*** and although that may ultimately be required, we would like the opportunity to exhaust all options prior to any extensive invasive treatment.

Enclosed please find copies of the American Association of Oral and Maxillofacial Surgeons (AAOMS) *Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParCare 2012)* and the *AAOMS Clinical Condition Statement*, both specific to treatment of the temporomandibular joint. The *AAOMS Parameters of Care* describes accepted patient management strategies, including guidelines, criteria and standards, and it provides a means to assess the appropriateness and quality of a selected treatment modality for application to an identified clinical condition.

The health consequences of conditions and diseases of the temporomandibular joint can be devastating. Dependence on pain medications, decreased productivity, and disability are common. Fortunately most patients who have extra-articular temporomandibular joint disorders can be successfully treated and rehabilitated with a combination of rest, medication, change in habits, and an orthotic appliance. However, those patients whose diagnosis is related to intra-articular pathology often cannot be treated successfully without surgical intervention.

Insert the following ONLY if information is applicable to your state and if it is not an ERISA plan. The state of ***insert your state*** has adopted legislation that prohibits ***insert state language such as, (discrimination in health and accident insurance against coverage involving certain bones and joints).*** This legislation prohibits health benefit plans from discriminating against coverage of procedures involving the bones or joints of the jaw, face, and head. Specifically, as I am confident ***insert company name*** is aware, "whenever a health benefit plan provides coverage for diagnostic, therapeutic, or surgical procedures involving bones or joints of

Patient Name
Patient I.D.
Date of Service

the human skeletal structure, that plan may not exclude or deny the same coverage for a procedure involving any bone or joint of the jaw, face or head, so long as the procedure is medically necessary to treat a condition which prevents normal functioning of the particular joint or bone and the condition is caused by a congenital deformity, disease, or traumatic injury." I would like to know that the legislation that has been enacted in this state is being followed.

On behalf of ***insert patient name***, thank you in advance for your attention and reconsideration of benefits for these services. Please do not hesitate to contact me if you have any additional questions or concerns.

Sincerely,

OMS Name and Degree

cc: Patient/Guarantor