

# THE APPEALS PROCESS

*Step-by-step: Level 1, Level 2, and external review*

What to say, what not to say, and how to frame your case.

*This guide is for informational purposes only and does not constitute legal, medical, or financial advice.*

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## Why Appeals Work

A denial is often not a final decision. Many services are approved after additional documentation or a formal appeal. Understanding how the appeals process works helps you navigate it with less uncertainty.

*An internal appeal decision is not final. External review decisions are legally binding on your insurer. These tools exist precisely for situations where the plan has denied your request.*

## Step 1 — Read the Denial Notice Carefully

The denial notice is required to state the specific reason for denial and the criteria not met. Use the exact wording from the notice when discussing the case with your provider's office.

- Locate the specific reason for denial
- Note any criteria cited by name or number
- Record the denial date
- Find the appeal deadline — critical, often 30-60 days
- Note any reference or case number
- Keep the original notice — do not discard

## Step 2 — Identify What Is Missing

Most successful appeals focus on supplying the specific documentation that addresses the stated reason for denial. In many cases, the information already exists but was not included in the original submission.

If the denial reason is...	The missing information is likely...
Incomplete documentation	Prior treatment history, functional impact statements, outside records, pharmacy history
Step therapy not met	Specific documentation of prior medications tried, duration, outcomes, and why they were stopped
Diagnosis mismatch	Relevant comorbidities or secondary diagnoses not included; incorrect ICD code submitted
Insufficient severity	Specific functional limitations not documented; general descriptions need specific examples
Administrative error	Incorrect insurance ID, missing forms, wrong payer, coding error — correct and resubmit
Not medically necessary	Clinical notes insufficient; peer-to-peer review may be most effective path

## Step 3 — Choose Your Path

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Option	Best Used When
Resubmit with additional documentation	Missing information has been identified and can be supplied quickly
Internal appeal	Clinical basis for denial is disputed or documentation is now available
Peer-to-peer review	Denial appears to be based on insufficient understanding of the clinical case
External review	Internal appeals have been exhausted and denial is believed to be incorrect
State/regulatory escalation	Insurer is not following required processes or consumer rights are at issue

### Peer-to-Peer Review

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A peer-to-peer review is a direct conversation between your treating provider and a physician reviewer at the insurance company. It can be helpful but has important limitations.

**When it helps most:**

- When documentation is complete but clinical context is complex
- When the reviewer may not have specialty expertise
- When the denial reason is medical necessity rather than missing information
- When the treating provider can speak specifically to why alternatives are not appropriate

**Its limitations:**

- The reviewer must still apply plan criteria — it is not a negotiation
- Missing documentation cannot be supplied verbally during the call
- Approval is not guaranteed even with a compelling clinical argument

*Act quickly. Appeal deadlines are typically 30-60 days from the denial date and are strictly enforced. Missing the deadline may eliminate your right to appeal entirely.*

### External Review: Your Most Powerful Option

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External review is conducted by an independent organization with no affiliation to your health plan. It is typically available after internal appeals are exhausted.

- External review is free under the ACA for most plans
- The reviewer's decision is binding on the insurer
- You do not need a lawyer
- File through your appeal denial letter or contact your state Department of Insurance
- For Medicare plans, file through the Medicare appeals process

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