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| APTA Template Letter: Provider to Payer to Request Code Exclusions Policy Change |

This template is to be used by the provider to convey the adverse impact of a coding exclusion on the clinic’s patent population and to request a change in policy.

Insert the applicable information in brackets and create a letter to mail or email to the appropriate agency.

REMINDER: Delete the header, these instructions, and any other bracketed language below prior to submitting your letter.

[DATE]

[NAME/TITLE OF ADDRESSEE]

[INSURER NAME]

[ADDRESS]

Attn: [FIRST/LAST NAME]

Reference Number: [INSERT NUMBER]

[PATIENT NAME, ID#, DATE OF SERVICE]

Re: [HEALTH PLAN] Coding Exclusions

Dear [TITLE/LAST NAME]:

On [DATE] [HEALTH PLAN] implemented coding exclusions that impede my ability to deliver evidence based, medically appropriate services based on sound clinical judgement to [HEALTH PLAN] enrollees. Please accept this letter as a request for [HEALTH PLAN] to consider rescinding these policy exclusions.

**Background**

My clinic treats a patient population for whom the excluded services may be indicated for an optimal outcome. [EXPLAIN IN NARRATIVE FORMAT SPECIFICS ABOUT YOUR PRACTICE AND HOW AND WHICH OF THESE EXCLUSIONS WILL ADVERSELY IMPACT YOUR PATIENT POPULATION/ TYPE OF DIAGNOSES].

As a licensed physical therapist, it is my professional responsibility to perform an initial examination, analyze the findings, engage patients based on their goals, and apply my professional judgment to establish a plan of care to effectively address each patient’s functional limitations. The excluded services are integral to successful implementation of the plan for a percentage of patients. The inability to incorporate these effective interventions will adversely impact return to function and ultimately increase the overall cost of care.

**Denied Services**

[MODALITY] is frequently used in response to the specific diagnosis(es) of [DIAGNOSIS(ES)]. This service is consistent with generally accepted standards of care. [CITE PEER REVIEWED MEDICAL LITERATURE IF AVAILABLE]. Furthermore, the services are clinically appropriate and designed to meet the individualized needs of each patient. [LIST TYPE, FREQUENCY, EXTENT, SITE, DURATION OF SERVICES. DISCUSS HOW SUCH SERVICES ARE CLINICALLY APPROPRIATE WITH REGARD TO EACH FACTOR]. The services are considered effective to improve symptoms associated with [DIAGNOSIS], specifically [SYMPTOMS LISTED ABOVE].

Medically necessary services or supplies are those that are reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. As described above, the excluded services meet this standard. Based on the information provided, I look forward to your reconsideration of the policy exclusion for [MODALITY] or [MODALITIES].

Thank you for your consideration.

Respectfully submitted,

[NAME]

[ADDRESS]

[TELEHONE]

[EMAIL]

Enclosures:

[LIST ANY ENCLOSURES YOU’RE INCLUDING. IF THERE ARE NO ENCLOSURES, DELETE THIS SECTION.]