Meridian Valley Health System

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PATIENT FINANCIAL ADVOCACY WORKFLOW

Document
Denial and appeal workflow
Owner
Patient Financial Advocacy
Version
5.3 · Effective 04/01/2027
Advocate line
1-855-555-0136

A Denial Is a Decision, Not the End of the Process

How to read the denial, look up the reason code, choose correction or appeal, and meet every deadline

EVERY DEADLINE ON THIS PAGE RUNS FROM MAY 28, 2027

Corrected claim by August 26, 2027 · First-level appeal by November 24, 2027. Missing a filing deadline usually ends the option permanently, even when the underlying claim was correct.

SPECIMEN CLAIM	DATE OF SERVICE	DENIED SERVICE	BILLED AMOUNT
2027-1203-50914	**May 2, 2027**	**CPT 74177 — CT abdomen and pelvis with contrast**	**$2,918.00**
PLAN	REMITTANCE DATE	DENIAL CODE	AMOUNT AT RISK
Cascade Ridge Health Plan	**May 28, 2027**	**CARC 197 with RARC N705 · plan code CRH-DN-412**	**$2,918.00 pending redetermination**

STEP 1 — READ THE DENIAL BEFORE REACTING TO IT

1. Find the remittance date. It is the date every deadline counts from, not the date of service and not the date you opened the envelope. Here it is **May 28, 2027**.
2. Find the claim number and confirm it matches the service you are asking about. One visit can generate several claims from several billing entities.
3. Find the denial code or codes. There are usually two: a claim adjustment reason code (CARC) that says *why*, and a remittance advice remark code (RARC) that says *what is missing*.
4. Find the amount the plan assigned to the patient. A denial for a missing authorization is an administrative problem between the plan and the provider; it should not sit on the patient.
5. Find the appeal instructions printed on the notice itself. The plan's own notice controls the address, the form, and the filing window.

Do not pay a denied balance in order to make it go away. Paying does not withdraw the denial, and a refund after a successful appeal takes longer than the appeal itself.

STEP 2 — LOOK UP THE REASON CODE

CODE	PRINTED TEXT ON THE REMITTANCE	WHAT IT ACTUALLY MEANS	USUAL PATH
CARC 197	Precertification, authorization, or notification absent	The plan required advance approval for the service and has no record of one on file for this date and this code. It is not a statement that the service was unnecessary.	Correction or retro-authorization
RARC N705	Incomplete or invalid documentation	The plan received something but not enough of it. Usually the ordering note, the prior imaging result, or the authorization number is missing.	Correction with records
CARC 16	Claim lacks information required for adjudication	A data element on the claim itself is missing or malformed — a modifier, a referring provider NPI, or a place-of-service code.	Corrected claim
CARC 50	Not deemed a medical necessity by the payer	The plan applied a clinical policy and concluded the documentation did not meet it. This is a clinical judgment and is appealable with clinical evidence.	Clinical appeal
CARC 27	Expenses incurred after coverage terminated	The plan on file had ended before the date of service. Frequently an eligibility record problem rather than an actual lapse.	Eligibility correction
CARC 18	Exact duplicate claim or service	The plan matched this claim to one it already processed. Sometimes correct, sometimes a legitimate repeat service that needs a modifier.	Corrected claim
CRH-DN-412	Advanced imaging outside the radiology benefit management program	A plan-specific code layered on top of CARC 197. The plan delegates advanced imaging review to a vendor and no vendor authorization exists.	Vendor retro-review

A code is a starting point, not a verdict. Two claims carrying the identical code can need completely different responses depending on what the medical record actually contains.

STEP 3 — DECIDE BETWEEN A CORRECTION AND AN APPEAL

IF THE PROBLEM IS…	THE RIGHT PATH IS…	WHO FILES IT	FILING WINDOW	DEADLINE HERE
A wrong or missing data element on the claim	Corrected claim (frequency code 7)	Provider billing office	90 days from remittance	August 26, 2027
An authorization that exists but was not on the claim	Claim reconsideration with the authorization number	Provider billing office	90 days from remittance	August 26, 2027
An authorization that was never obtained	Retrospective authorization request to the imaging vendor	Ordering clinician's office	60 days from date of service	July 1, 2027
Eligibility shown incorrectly on the plan's file	Eligibility correction, then claim reprocessing	Patient and employer or plan	No fixed window; do it immediately	—
A clinical policy the plan applied to the documentation	First-level internal appeal with clinical records	Patient, or provider with authorization	180 days from remittance	November 24, 2027
An internal appeal that was denied	Second-level internal appeal	Patient or authorized representative	60 days from the first-level decision	Set by the decision letter
A final internal denial of a medical necessity question	Independent external review	Patient or authorized representative	4 months from the final internal denial	Set by the final letter

A correction is faster and is usually the right first move. An appeal preserves rights but restarts a formal clock. When both are available, file the correction and calendar the appeal deadline as a backstop — do not let the appeal window close while a correction is pending.

STEP 4 — EVIDENCE CHECKLIST BY DENIAL CATEGORY

DENIAL CATEGORY	EVIDENCE THAT ACTUALLY MOVES THE DECISION
Authorization absent (CARC 197)	Authorization or reference number and date obtained; vendor call log; ordering note showing the request predates the service; plan's own policy excerpt
Documentation incomplete (RARC N705)	Signed ordering note; prior imaging report and date; relevant clinic notes; the exact records the remittance says are missing
Medical necessity (CARC 50)	Letter of medical necessity from the ordering clinician; the plan's published clinical policy with the criteria met and cited; failed conservative measures with dates
Eligibility (CARC 27)	Current insurance card, front and back; employer coverage verification letter; effective date from the plan's enrollment record
Duplicate (CARC 18)	Both claim numbers; the operative or procedure note showing two distinct services; timing documentation supporting the repeat

STEP 5 — TRACK THE STATUS STAGES

STAGE	WHAT IT MEANS	STANDARD
Received	The plan has logged the submission and issued a reference number	Acknowledged within 5 business days
Under review	A reviewer is assigned; for clinical appeals a like-specialty reviewer is required	In progress
Information requested	The clock may pause until the requested records arrive	Respond within 14 days
Decision issued	A written determination stating the basis and the next right	Pre-service 30 days · Post-service 60 days · Expedited 72 hours
Closed	No further internal review is available at this level	External review may still be open

Ask for the reference number at every contact and write down the date, the representative's name, and what you were told. A contact log is the single most useful document in a prolonged appeal.

APPEAL PACKET COVER SHEET — COMPLETE ONE PER CLAIM

PATIENT NAME	DATE OF BIRTH	MEMBER ID	GROUP NUMBER
CLAIM NUMBER	DATE OF SERVICE	DENIED CODE(S)	REMITTANCE DATE
DEADLINE (REMITTANCE + 180 DAYS)	SUBMISSION LEVEL **First internal / Second internal / External**	SUBMITTED BY **Patient / Authorized representative / Provider**	DATE SUBMITTED

Documents enclosed — check each one included and number the pages consecutively:

- ☐ Copy of the remittance advice or denial notice
- ☐ Copy of the itemized statement for the same claim
- ☐ Signed appeal or authorized-representative form
- ☐ Letter of medical necessity from the ordering clinician
- ☐ Relevant clinical notes, limited to the date range at issue
- ☐ Prior imaging or laboratory results referenced in the notes
- ☐ Authorization or vendor reference number and call log
- ☐ Contact log listing every call, date, and reference number

Proof of filing: Send by a method that produces proof of delivery and keep the receipt with the packet copy. For a fax, keep the confirmation page. For certified mail, keep the return receipt. Proof of timely filing has decided more appeals than any clinical argument.

WHAT WE CAN DO FOR YOU

- Re-review the coding and documentation on our claim at no cost.
- File a corrected claim or a reconsideration when the error is ours.
- Supply the medical records you need for an appeal, at no charge when the records support an appeal of a denied claim.
- Hold the account while a documented appeal or dispute is pending.
- Connect you with a patient financial advocate at 1-855-555-0136.

WHAT WE CANNOT DO

- We cannot file an internal appeal in your name without a signed authorized-representative form.
- We cannot change the plan's clinical policy or its filing deadlines.
- We cannot tell you the appeal will succeed, and no one who can should.
- We cannot give legal advice or represent you in an external review proceeding.
- We cannot waive a balance that a plan has correctly assigned as patient cost share, outside of the financial assistance policy.

Important: Nothing in this workflow promises that a denial will be reversed, and no part of it is legal, insurance, or clinical advice. The plan's written notice controls the filing addresses, the deadlines, the review levels, and your external review rights. Where this page and that notice disagree, the notice controls.

FICTIONAL SPECIMEN. Meridian Valley Health System, Cascade Ridge Health Plan, the specimen claim number, the denial and remark codes as applied here, the plan-specific code CRH-DN-412, the vendor program, the dates, the deadlines, and the dollar amounts are invented for demonstration only. Real reason codes, filing windows, and appeal rights vary by plan, product, and state. This is not a real denial notice, appeal form, or statement of appeal rights.