Insurance Denial Response Tracker

A printable log for organizing celiac-related insurance denials and the appeals that follow. Record one denied claim per row, set the appeal deadline, and work the row until it resolves. Prefer to work on screen? The same tracker is available as an Excel workbook and a Google Sheets version, both with automatic deadline highlighting.

Claim Date	Provider	Service / Item	Amount	Denial Date	Denial Code	Denial Reason (plain English)	Appeal Deadline	Appeal Submitted	Method	Follow Up	Status	Outcome / Notes

Deadline status, when you work this on screen: the Excel and Google Sheets versions color each row automatically.

Within 14 days	Appeal deadline is near. Prepare and submit your appeal now.
Past due	Deadline has passed and the claim is still open. Escalate to external review or your state insurance commissioner.
Resolved	Claim closed. Keep the row for your records and as precedent for future appeals.

Reference Guide

Read-only reference. Verify all deadlines and requirements against your specific plan documents and denial letter. This guide is general educational information, not legal or medical advice.

Section 1 — Common denial reason codes

Item	What it means and what to do
CO-50 / PR-50	Not medically necessary, per the payer's clinical criteria. The most common denial for celiac care (endoscopies, dietitian visits, lab panels). Appeal with a detailed Letter of Medical Necessity from your gastroenterologist, your biopsy and serology results, and published clinical guidelines (ACG, AGA). Generic 'medically necessary' language without clinical detail will not move a reviewer.
CO-96 / PR-96	Non-covered charge, service excluded from your plan. Review your Summary of Plan Benefits for the exclusion language. If the exclusion is applied incorrectly, or the service should be covered under ACA preventive-care provisions or a state mandate, appeal in writing citing the specific plan language and applicable law.
CO-11	Diagnosis code inconsistent with the procedure. The correct ICD-10 code for celiac disease is K90.0. Ask your provider to verify the code and resubmit. If K90.0 is already there, request a peer-to-peer review.
CO-16	Claim missing information needed for adjudication. Request your full Explanation of Benefits (EOB) to identify what is missing (NPI, referral number, prior authorization, modifier), then have your provider resubmit.
CO-4	Missing or inconsistent modifier. A billing error, not a coverage decision. Your provider corrects the coding and resubmits.
CO-97	Bundling: benefit included in the payment for another service. If the services are clinically distinct, appeal with documentation explaining why they should be reimbursed separately.
CO-167	Diagnosis not covered. Ensure K90.0 is on the claim. If it is, appeal citing medical necessity and the clinical link between the diagnosis and the service.
N362	Units or visits exceed utilization guidelines. Appeal with documentation of medical necessity for the specific frequency your physician prescribed.
N479 / N517	Prior authorization required and not obtained, or does not match the service billed. Ask your provider to request a retroactive authorization, or verify the service codes match exactly.

Codes listed are standard ANSI X12 CARC/RARC codes. Your EOB may display them differently. You have a legal right to the full EOB and the plan's written coverage criteria for any denied service.

Section 2 — Standard appeal deadlines by insurance type

Item	What it means and what to do
Commercial — ERISA / self-funded	Internal appeal: typically 180 days from the denial notice. External review: 4 months after exhausting internal appeals. ERISA self-funded plans are federally regulated; complaints go to the U.S. Department of Labor (EBSA), not your state insurance commissioner.
Commercial — fully insured	Internal appeal: typically 180 days. External review available after internal appeals are exhausted, through your state insurance commissioner. Subject to both federal (ACA) and state law.
ACA marketplace / individual	Internal appeal: 180 days. External Independent Medical Review (IMR) after internal appeal, or if the plan misses its own deadlines. File at healthcare.gov or with your state commissioner.
Medicare Part A & B	Level 1 Redetermination: 120 days from the Medicare Summary Notice. Five appeal levels total. Free SHIP counseling at shiphelp.org.
Medicare Advantage (Part C)	Internal appeal: 60 days from the denial. Expedited decision within 72 hours for urgent cases. Then the Independent Review Entity.
Medicaid — traditional	Fair Hearing: typically 90 days, but varies significantly by state (30 to 120 days). Your state Notice of Action states the exact deadline. Do not rely on general guidance.
Medicaid managed care	Internal grievance/appeal: typically 60 days, state-specific. State Fair Hearing after the internal process. Check your member handbook and state agency.
TRICARE (military)	Reconsideration: 90 days. Formal review: 90 days from the reconsideration decision.

The deadline printed on your denial letter or EOB is your actual deadline, not the general guidance above. When in doubt, assume the shortest deadline and act immediately. Missing an appeal deadline almost always forfeits the right to appeal that denial.

Section 3 — What to include in a celiac disease appeal

Item	What it means and what to do
Appeal cover letter	Factual, under two pages. State your name, member ID, claim number, date of service, date of denial, and the service denied. Reference every enclosure. Clinical and direct, not emotional.
Copy of the denial letter / EOB	Include the original denial notice and the full EOB. Highlight the denial code and the appeal deadline. This establishes the administrative record.
Letter of Medical Necessity (LMN)	The most important document for CO-50 and CO-96 denials. On physician letterhead (gastroenterologist preferred): the K90.0 diagnosis, the specific service requested, why it is medically necessary (cite lab values, biopsy results, symptom history), the consequences if it is not provided, the physician's signature, NPI, and date.
Diagnosis documentation	Pathology report from intestinal biopsy (Marsh classification, villous atrophy), positive serology (tTG-IgA, EMA, or DGP), the physician's diagnosis note, and HLA-DQ2/DQ8 genetic testing if available.
Peer-reviewed clinical guidelines	Relevant excerpts from the ACG Clinical Guideline on Celiac Disease, AGA guidelines, and Celiac Disease Foundation resources (celiac.org). Print and highlight the applicable passages.
Itemized bill	Request the itemized bill, not the summary statement. Each line must show the CPT code, description, date, and charge.
Proof of submission	Certified mail with return receipt, a portal confirmation screenshot, or a call log with the representative's name and reference number. Insurance companies lose documents; prove what you sent and when.
Regulatory citations (if relevant)	ACA plans: 45 CFR 147.136 (internal appeals) and 147.138 (external review). ERISA plans: 29 CFR 2560.503-1. Citing the rule signals you know your rights.

Section 4 — When and how to escalate

Item	What it means and what to do
External Independent Medical Review (IMR / IRE)	Use after internal appeals are exhausted, or if the insurer missed its own deadline. ACA plans: healthcare.gov or your state commissioner. Medicare: the QIC. Medicaid: a State Fair Hearing. Independent of your insurer, and free to the consumer under the ACA.
State insurance commissioner	For fully insured commercial plans when the insurer is unresponsive, missed a deadline, or appears to be violating state law. File at naic.org/state_web_map.htm. Limited jurisdiction over ERISA self-funded plans.
U.S. Department of Labor (EBSA)	For ERISA self-funded employer plans. File at dol.gov/agencies/ebsa or call 1-866-444-3272. Creates a federal record of the dispute.
Patient advocate / hospital financial counselor	Free at most institutions. They know the insurer's internal contacts and handle denials daily.
Celiac advocacy organizations	Celiac Disease Foundation (celiac.org) and Beyond Celiac (beyondceliac.org) offer advocacy support and sample appeal letters.
Healthcare attorney / legal aid	For large amounts, bad-faith patterns, or possible ADA / ACA Section 1557 violations. Many work on contingency. ERISA limits available damages; consult an ERISA-experienced attorney.

Documentation rule: log every phone call (date, time, representative name, reference number, summary). Written communication is always preferable because it creates a paper trail.

Section 5 — Celiac-specific coverage notes

Item	What it means and what to do
ICD-10 code	K90.0 (celiac disease, also called gluten-sensitive enteropathy). Make sure it appears on every celiac-related claim. A wrong or missing diagnosis code is one of the most common and most fixable causes of denial.
Commonly denied celiac services	Endoscopy/biopsy (CPT 43239, 43235, 43240), celiac antibody panels (CPT 86200, 86235), medical nutrition therapy/dietitian visits (CPT 97802 to 97804), bone density scans (CPT 77080), genetic testing (CPT 81376), follow-up endoscopy, and capsule endoscopy (CPT 91110). All have clinical guideline support.
Gluten-free diet as treatment	A strict gluten-free diet is the only evidence-based treatment for celiac disease, but most health plans do not cover the cost of gluten-free food. An FSA or HSA may cover the incremental cost difference with a physician's prescription. Some state Medicaid programs have medical-food provisions. Keep receipts and document the price difference.
Tracking the gluten-free premium	For someone with a celiac diagnosis, the cost difference between a gluten-free item and its conventional counterpart is the gluten-free premium. People track it across the year and bring the total to their CPA or tax professional, who decides what is reportable on Schedule A.
Coordinate with your provider	Ask the billing staff to verify K90.0 and the correct CPT codes on every claim, provide a Letter of Medical Necessity on letterhead, and participate in a peer-to-peer review with the insurer's medical director. Peer-to-peer review is one of the most effective tools for overturning a medical-necessity denial.

This reference is general educational information only. It does not decide what is claimable on your tax return, and it is not legal, medical, or financial advice. Insurance rules change. Verify current rules with your plan documents, your state insurance commissioner, and a qualified professional. Review any gluten-free premium total with your CPA or tax professional before filing.