

FICTIONAL SAMPLE: an invented case, not a real patient, clinic or claim. Prepared with ClaimParrot to show what a packet looks like.

CLINICAL APPEAL

[Date]

[Payer appeals address]

Re: Clinical Appeal — Denial of Continued Partial Hospitalization Authorization

Member: [Member name]

Member ID: [Member ID]

Provider: [Provider name] | NPI: [NPI]

Dates of Service: [Dates of service]

Authorization / Claim Reference: [Authorization/claim number]

Review Stage: Concurrent review — First-level clinical appeal

The treating program submits this clinical appeal of Optum / United Behavioral Health's decision to deny authorization for continued partial hospitalization (PHP) beyond day 10 of the member's current PHP stay. The denial should be overturned because the payer's stated rationale — symptom improvement and absence of imminent risk — does not address the clinical record as documented: the member continued to report passive suicidal ideation most days as of day 9; the safety plan was revised on day 8 following the member's disclosure of access to stockpiled medication in the home, which family removed on day 9; the treating psychiatrist documented on day 6 that the response to a sertraline increase cannot be evaluated before day 14; and the treatment team documented on day 9 that the member cannot yet safely manage the 20 hours per day outside programming due to ongoing home conflict with a partner. Each of these findings is directly relevant under LOCUS and the Optum Behavioral Clinical Policy for partial hospitalization.

The Payer's Stated Reason and the Clinical Record

The notice states: 'Continued partial hospitalization is not medically necessary. The member's symptoms have improved, the member is no longer at imminent risk of harm to self, and the member's needs can be met at a less intensive level of care such as intensive outpatient. Authorization ends after day 10 of the PHP stay.'

Each element of that rationale is addressed directly below.

1. Symptom improvement during active PHP does not establish step-down readiness.

The member's PHQ-9 score was 24 on admission and 19 on day 9. While any directional change is clinically relevant, a PHQ-9 of 19 on day 9 does not reflect resolution of the presenting condition. More

to the point, the treating team documented that the member continued to report passive suicidal ideation most days as of day 9 — this is not a finding of resolved symptoms. Symptom improvement during PHP is an expected treatment response. It does not, standing alone, establish that treatment goals have been met or that transition to a lower level of care is clinically appropriate at that point in the episode. The notice does not identify which treatment goal was achieved that would support safe step-down.

2. The documented safety profile was not resolved by day 10.

The notice states the member 'is no longer at imminent risk of harm to self.' The clinical record shows that on day 8, the member disclosed access to stockpiled medication in the home. The safety plan was revised that same day. Family removed the stockpiled medication on day 9. This sequence reflects a risk that emerged during the PHP stay and had not been fully stabilized by day 10. The notice does not address the day-8 safety plan revision, the means-access disclosure, or the passive suicidal ideation reported most days as of day 9. A clinical safety profile is not resolved by the absence of imminent risk alone when these documented facts remain present.

3. The treating team's step-down readiness criteria have not been met.

On day 9, the treatment team discussed and documented that transition to IOP was premature. The documented reason is that the member cannot yet maintain safety for the 20 hours per day outside programming because the home environment includes ongoing conflict with a partner. The discharge plan, as documented, requires that passive suicidal ideation resolve for 5 consecutive days and that the medication trial reach 14 days before IOP transition is appropriate. As of day 9, neither condition had been reached. The notice does not address either step-down criterion or the documented environmental barrier the team identified.

4. The medication trial is incomplete.

Sertraline was increased on day 6. The treating psychiatrist documented at that time that the response to this increase cannot be judged before day 14. The notice does not address this documented clinical finding. Transitioning the member to IOP before day 14 removes structured daily monitoring during a period the treating psychiatrist has identified as necessary to evaluate the medication change.

5. What the notice does not address.

The notice does not address: the day-8 safety plan revision; the day-9 means-access disclosure and removal of stockpiled medication from the home; the treating psychiatrist's documented finding that medication response cannot be evaluated before day 14; the treatment team's specific step-down readiness criteria (passive ideation resolved for 5 consecutive days; medication trial at 14 days); or the documented environmental barrier — ongoing home conflict — that the team cited as the specific reason the member cannot safely manage 20 hours per day outside programming.

Clinical Risk of Upholding the Denial

This member was admitted to PHP following an emergency department visit for suicidal ideation with a plan. As of day 9, the member continues to report passive suicidal ideation most days. A new means-

access risk was identified on day 8. The treating team has documented a specific environmental barrier that makes safe step-down premature. Upholding the denial and transitioning the member to IOP before the team's documented step-down criteria are met would remove the level of daily structured monitoring the treating team has identified as currently necessary to manage these factors.

Applicable Criteria

The criteria named in the notice are LOCUS and the Optum Behavioral Clinical Policy for partial hospitalization. This appeal requests that those criteria be applied to the full clinical record described above. The notice does not identify which specific LOCUS dimension or dimensions were scored below the threshold for continued PHP, what score was recorded for each, or what score would be required to support continued stay. The treating program requests that information in any response to this appeal.

If the treatment plan and day-8 through day-9 clinical documentation were not before the reviewer at the time of the concurrent review determination, please consider them now.

Requests

1. Overturn the denial and authorize continued PHP beginning day 11 of the current stay for the days and units the clinical record supports; and, to the extent PHP has been provided on days for which authorization has not yet been issued, reprocess and pay those days.
2. Authorize continued PHP at the current level while this appeal is being decided, as the member remains in active treatment.
3. Identify the specific LOCUS dimension or dimensions and the criterion under the Optum Behavioral Clinical Policy for partial hospitalization that the reviewer found unmet, including the score or finding recorded at the time of the concurrent review; and provide access to the plan documents and claim file materials relevant to this determination.
4. If this plan makes peer-to-peer or same-specialty review available for this determination, please arrange it; otherwise identify the available clinical-review pathway. Given the care setting, please have any reviewing clinician share the specialty this clinical profile points to — psychiatry.

This matter is clinically urgent. The member is currently attending PHP and authorization status directly affects continuity of an active treatment episode.

Respectfully submitted,

[Provider / authorized representative name]

[Title]

[Provider name]

NPI: [NPI]

Phone: [Phone]

Fax: [Fax]

[Date]

FICTIONAL SAMPLE: an invented case, not a real patient, clinic or claim. Prepared with ClaimParrot to show what a packet looks like.

Appeal packet guide

Level-of-care packet · Partial hospitalization (PHP) · Optum / UnitedHealthcare (UBH) · Continued stay / concurrent review · First-level appeal

Prepared by ClaimParrot for Fictional Sample Clinic, to use with 02-appeal-letter.docx. In this guide: 1. The approach; 2. Evidence checklist; 3. Deadline and escalation plan; 4. Level-of-care criteria crosswalk; 5. Peer-to-peer review brief.

How to use this packet

1. **Fill in the placeholders.** Open 02-appeal-letter.docx and replace every bracketed placeholder: [Date], [Payer appeals address], [Member name], [Member ID], [Provider name], [NPI], [Dates of service], [Authorization/claim number], [Provider / authorized representative name], [Title], [Phone], [Fax]. We worked from a de-identified summary and never had the member's details, so nothing was guessed.
2. **Attach the records.** Work through the evidence checklist below and attach each record that applies, covering the dates under review. Attach nothing you haven't checked.
3. **Clinician review and signature.** The treating clinician reads the letter, corrects anything that doesn't match the chart, and signs it. Your team submits the appeal to the plan; ClaimParrot does not contact the payer.
4. **Deadline.** You told us 30 days were left when you sent the case on Oct 19, 2026, so the working deadline is Wednesday, November 18, 2026. Confirm it on the denial notice: the notice wins. The deadline and escalation plan below has the details and the next appeal levels.
5. **PDF, if the plan wants one.** Fill in the placeholders first, then save the letter as a PDF from Word (File > Save As > PDF).
6. **Peer-to-peer.** If the plan offers a peer-to-peer review, ask for it early; the treating clinician can prepare with the brief at the end of this guide.

1. The approach

The letter is drafted as a **clinical appeal** for a first-level appeal. For an active authorization or concurrent-review denial, follow the clinical appeal instructions in the adverse determination.

Before you file:

- ☐ Confirm whether the member's condition supports an expedited review and route that determination to a qualified clinician.
- ☐ Record every payer representative name and call reference number.
- ☐ Match the route to the member's exact plan, product, service date, and state.
- ☐ Use the submission method and address printed on the adverse-benefit notice.
- ☐ Save the confirmation number, timestamp, and a copy of the complete packet.

Watch for:

- Some Optum products and states do not use the same two-step reconsideration and appeal process.
- The adverse-benefit notice and member plan control when they conflict with this workflow guide.

The payer's own guidance: Optum Provider Express, <https://www.providerexpress.com/> (our route guide was last checked Jul 14, 2026).

2. Evidence checklist

The plan's reviewer can only overturn the denial on what the record shows. Attach the records below to the appeal, and make sure each one covers the dates under review. Do not attach anything you have not checked yourself.

1. Records the letter relies on

Each one backs a statement in the letter or answers the payer's stated reason.

- ☐ Obtain: Treating clinician-signed letter of medical necessity documenting current symptom severity, functional impairment, active treatment goals not yet achieved, clinical barriers to step-down, and prognosis if PHP is terminated prematurely — letter should address the specific criteria cited in the notice (LOCUS; Optum Behavioral Clinical Policy for partial hospitalization)
- ☐ Obtain: PHP program records documenting passive suicidal ideation reported most days through day 9, the PHQ-9 scores (24 on admission, 19 on day 9), and any additional symptom-rating or functional measures recorded during the stay
- ☐ Obtain: Day-8 safety plan revision documentation and the clinical note describing the member's disclosure of access to stockpiled medication
- ☐ Obtain: Day-9 clinical note documenting family removal of stockpiled medication and the team's step-down discussion, including the documented finding that IOP transition is premature due to the home environment
- ☐ Obtain: Day-6 psychiatrist note documenting the sertraline increase and the documented finding that medication response cannot be evaluated before day 14
- ☐ Obtain: Written discharge/step-down readiness criteria as documented by the treating team (passive ideation resolved for 5 consecutive days; medication trial at 14 days), with clinical rationale for why those criteria have not yet been met
- ☐ Obtain: Risk assessment documentation covering subacute and chronic risk factors, not limited to imminent dangerousness — including means-access history, protective factors, and environmental stressors
- ☐ Obtain: Documentation of any prior treatment at a lower level of care (IOP or outpatient) before this PHP episode, including outcomes, to address the payer's assertion that IOP is an adequate step-down
- ☐ Obtain: Full text, version number, and effective date of the Optum Behavioral Clinical Policy for partial hospitalization cited in the notice

- ☐ Obtain: Name, licensure type, and clinical specialty of the Optum / UBH reviewer who issued the adverse determination
- ☐ Verify: Member's current ICD-10 diagnosis code(s) for inclusion in the appeal packet
- ☐ Verify: LOCUS scores recorded at admission and at the concurrent review, if available from the payer's determination or the treating program's records

2. Level-of-care gaps to close (from the criteria crosswalk)

Each line is a criterion the record supports only partly or not at all. Document it, or have the treating clinician address it in the letter of medical necessity.

- ☐ **Symptom improvement** (partly supported): Treating clinician's signed letter documenting residual symptoms on day 10, current PHQ-9 score, passive suicidal ideation frequency, and active treatment goals not yet achieved; daily symptom logs for the denied dates

3. Confirm on the denial notice

We worked from a de-identified summary, so these come from the notice and the chart, not from us.

- ☐ The filing deadline and how the plan counts it. If it differs from the working deadline in this guide, the notice wins.
- ☐ Where and how to send the appeal (address, fax or portal) and any form the plan requires with it.
- ☐ The route and level: the letter is drafted as a clinical appeal (first-level appeal).
- ☐ The criteria set and version the reviewer applied (you told us: LOCUS; Optum Behavioral Clinical Policy for partial hospitalization).
- ☐ Whether the notice offers an expedited appeal, and whether care can continue while the appeal is decided.
- ☐ Whether the plan needs the member's written authorization for your team to appeal on their behalf.
- ☐ The member, claim, authorization and date-of-service details for the letter's placeholders.

4. Standard records for this type of denial

The usual packet for this denial type. Skip any that do not apply.

- ☐ Adverse-benefit determination and every page of the payer notice
- ☐ Authorization history, reference numbers, and call notes
- ☐ Current treatment plan with measurable goals and progress
- ☐ Relevant clinical notes for the dates under review
- ☐ Progress since admission and remaining barriers to safe discharge
- ☐ Updated risk assessment and discharge-readiness criteria
- ☐ Step-down plan and why transition is not yet clinically appropriate

Before you send anything: fill every bracketed placeholder, remove nothing the plan needs to identify the member, and keep a copy of the complete packet with the submission confirmation.

3. Deadline and escalation plan

The denial notice and the member's plan documents control. Every date below is worked out from the days left you reported; ClaimParrot never supplies a filing deadline of its own.

1. The filing deadline

You told us **30 calendar days** were left to appeal when you sent this case on **Monday, October 19, 2026**. Counting from that day, the working deadline is **Wednesday, November 18, 2026**.

Aim to submit by **Tuesday, November 10, 2026**, about a week early, so a portal, fax or mail problem cannot cost you the appeal.

Check this against the date printed on the denial notice before you file. If the notice gives a different date, the notice wins.

If the member is still in care

Do not wait for the deadline. If the notice offers an expedited (urgent) appeal and the treating clinician believes the standard timeframe could seriously jeopardize the member's health, request it; expedited appeals are decided much faster than standard ones. Ask the plan at the same time whether care can continue while the appeal is decided.

2. What happens next

1. **First-level internal appeal** (this packet): The appeal to the plan. Use the address, fax or portal printed on the denial notice.
2. **Second-level internal appeal, if the plan has one**: The first-level decision letter says whether a second level exists and how long you have.
3. **External (independent) review**: After the plan's final internal denial, an independent reviewer outside the plan can decide medical-necessity and level-of-care disputes. The final denial letter must explain how to ask and the time limit. The member or an authorized representative usually files it, so get the member's written authorization early.

Alongside any level: ask for a peer-to-peer review with the plan's reviewer (see the peer-to-peer brief). It is often the fastest way to overturn a level-of-care decision.

3. General federal rules, for reference

The federal floors that apply while the plan type (employer, individual, Medicaid or Medicare) is not confirmed, last checked Oct 14, 2026. They are not your deadline; the notice is. State law and the plan can be more generous.

- **How to tell which rules apply**: Check the member ID card and the notice: Medicaid and Medicare Advantage plans say so; an employer plan names the employer; marketplace plans name the exchange. (29 CFR 2560.503-1)

4. Track it

- ☐ Deadline confirmed from the notice: _____

- ☐ Submitted on _____ by _____ (portal / fax / mail); confirmation number _____
- ☐ Decision expected by _____ (ask the plan when you submit)
- ☐ Outcome: overturned / partly overturned / upheld. Next step and its deadline: _____

4. Level-of-care criteria crosswalk

- Criteria source named in the denial: LOCUS; Optum Behavioral Clinical Policy for partial hospitalization
- Level of care at issue: Partial hospitalization program (PHP)
- The record supports the requested level of care on 3 of 4 points, in part on 1, and has nothing yet on 0

First gap to close: The single most important gap is a signed treating clinician letter of medical necessity that authenticates, in one document, the persistent passive suicidal ideation, the day 8 safety-plan revision triggered by medication access, the incomplete sertraline trial, and the unmet step-down criteria—without it, the appeal has no clinician-verified narrative to rebut the payer's symptom-improvement rationale or to document why IOP is clinically unsafe at this time.

Each row is a point the denial turns on, worded as the denial words it; the status column says whether the record supports the care you requested on that point, not whether the payer's statement is right. Quotes are copied word for word from the case summary you sent ("Claim description") or from the denial as you described it ("Denial notice"). Licensed criteria text (ASAM, LOCUS, InterQual, MCG) is never reproduced: check each row against the criteria version the reviewer used.

#	Point the denial turns on	Period	Evidence (verbatim)	Source	Record supports the requested care?	To obtain or document
1	Symptom improvement	Authorization ends after day 10 of PHP stay	"PHQ-9 went from 24 on admission to 19 on day 9"	Claim description	In part	Treating clinician's signed letter documenting residual symptoms on day 10, current PHQ-9 score, passive suicidal ideation frequency, and active treatment goals not yet achieved; daily symptom logs for the denied dates
2	Risk of harm to self (no longer at imminent risk)	Authorization ends after day 10 of PHP stay	"safety plan was revised on day 8 after the member disclosed access to stockpiled medication at home, which family removed on day 9"	Claim description	Yes	Obtain signed clinician risk assessment documenting ongoing passive suicidal ideation, the day 8 safety-plan revision, and subacute and chronic risk factors beyond imminent dangerousness; retain as primary appeal exhibit
3	Needs can be met at	Authorization ends	"step down to IOP when	Claim	Yes	Obtain treating team's

#	Point the denial turns on	Period	Evidence (verbatim)	Source	Record supports the requested care?	To obtain or document
	IOP level of care	after day 10 of PHP stay	passive ideation has resolved for 5 consecutive days and the medication trial has run 14 days"	description		written step-down readiness criteria with clinical rationale explaining why neither criterion is met by day 10; psychiatrist's progress note documenting that sertraline response cannot be assessed before day 14
4	Support and environment (general factor, not from the cited criteria)	Authorization ends after day 10 of PHP stay	"member could not yet maintain safety for the 20 hours a day outside programming because the home environment includes ongoing conflict with a partner"	Claim description	Yes	Obtain treating team's written documentation of specific home environment barriers, partner conflict, and their clinical impact on step-down safety; social work or case management note for days 9–10 if available

5. Peer-to-peer review brief

Read this in the two minutes before the call. Ask for the peer-to-peer as soon as possible: windows are short and set by the plan.

The plan's decision

Optum / UnitedHealthcare (UBH) has denied continued authorization for partial hospitalization (PHP) effective after day 10 of the current stay. The stated reasons are symptom improvement, absence of imminent risk of harm to self, and a conclusion that the member's needs can be met at intensive outpatient (IOP) level of care. The criteria cited are LOCUS and the Optum Behavioral Clinical Policy for partial hospitalization. The member is still attending PHP while this appeal is prepared.

Criteria cited: LOCUS; Optum Behavioral Clinical Policy for partial hospitalization

Open with

Thank you for speaking with me today. I am the treating clinician for a member currently in our PHP program who received a continued-stay denial effective after day 10. I want to walk you through the specific clinical findings that support ongoing PHP authorization and understand which criterion you found unmet, so we can resolve this quickly while the member is still in active treatment. I will keep this focused and factual.

Points and evidence

1. **Passive suicidal ideation is still present as of day 10 of the PHP stay. The denial characterizes the member as no longer at imminent risk, but suicidal ideation — passive or otherwise — remains an active clinical finding on the day authorization was cut.**

- Evidence: Treating program summary documents that on day 10 the member still reports passive suicidal ideation most days.
 - Where: Treating program clinical summary, day 10
2. **A new safety concern emerged mid-stay: the member disclosed access to stockpiled medication at home on day 8, requiring revision of the safety plan and family intervention to remove the medication on day 9. This is not a presentation consistent with step-down readiness; it reflects an active, evolving risk picture that was identified precisely because the member was still in structured PHP care.**
- Evidence: Safety plan was revised on day 8 after the member disclosed access to stockpiled medication at home. Family removed the medication on day 9.
 - Where: Treating program clinical summary, days 8–9
3. **The current medication regimen has not yet had adequate time to demonstrate a treatment response. The prescribing psychiatrist documented on or before day 10 that medication response cannot be judged before day 14. Discontinuing the PHP level of care at day 10 removes the clinical structure that is monitoring the member during this critical window.**
- Evidence: Sertraline was increased on day 6. The psychiatrist's documented note states that response cannot be judged before day 14.
 - Where: Treating program clinical summary, days 6–10
4. **The treatment team has specifically assessed step-down readiness and documented that the member cannot yet maintain safety during the 20 hours per day outside of programming, due to ongoing conflict with a partner in the home environment. This is a concrete, documented clinical barrier to IOP — not a general statement — and it was recorded on day 9.**
- Evidence: Treatment team documented on day 9 that the member could not yet maintain safety for the 20 hours per day outside programming because the home environment includes ongoing conflict with a partner.
 - Where: Treating program clinical summary, day 9
5. **The treating team has established explicit, objective discharge criteria for step-down to IOP: resolution of passive ideation for 5 consecutive days and completion of a 14-day medication trial. Neither criterion has been met as of day 10. Symptom improvement is expected during PHP; it does not mean treatment goals are achieved or that the established discharge criteria have been satisfied.**
- Evidence: Discharge plan documented by treating team: step down to IOP when passive ideation has resolved for 5 consecutive days and the medication trial has run 14 days. PHQ-9 moved from 24 on admission to 19 on day 9.
 - Where: Treating program clinical summary, days 1–10
6. **The denial notice does not appear to address the documented home-environment safety barrier, the day-8 safety plan revision, the ongoing medication titration, or the treating team's step-down readiness criteria. The notice addresses only imminent risk and symptom improvement.**
- Evidence: Denial reason as stated: symptom improvement, no imminent risk, IOP is sufficient. No mention of home conflict, stockpiled-medication incident, medication adjustment timeline, or the team's explicit discharge criteria.
 - Where: Denial analysis and treating program clinical summary

Risk if stepped down or discharged

Based on the treating program's documentation, the member still reports passive suicidal ideation most days as of day 10, has a recently revised safety plan following disclosure of access to stockpiled medication, is in the early phase of a medication adjustment that the prescribing psychiatrist has stated cannot be evaluated before day 14, and is returning each day to a home environment that the treatment team has documented as a barrier to maintaining safety during unstructured hours. The treating team has not certified the member as meeting step-down readiness criteria.

Ask for

1. Overturn the denial and authorize continued PHP for the dates of service at issue, based on the active clinical findings documented by the treating team.
2. At a minimum, authorize PHP through day 14 to allow the prescribing psychiatrist to assess the medication response as documented in the clinical record, and to allow reassessment of the home-environment safety barrier.
3. If continued PHP cannot be approved at this time, agree to a documented step-down plan tied to the treating team's stated criteria — resolution of passive suicidal ideation for 5 consecutive days and completion of the 14-day medication trial — and confirm those criteria in writing.

Questions for the reviewer

- What is your clinical specialty, and are you board-certified in psychiatry or addiction medicine?
- Which version of the LOCUS instrument did you apply during this concurrent review?
- Which specific criterion or criteria within LOCUS and/or the Optum Behavioral Clinical Policy for partial hospitalization did you find unmet?
- In your review, did you consider the day-8 safety plan revision related to stockpiled medication, the day-9 family intervention, the active medication titration with a documented 14-day assessment window, and the treating team's documentation of the home-environment safety barrier?
- Does the Optum Behavioral Clinical Policy for partial hospitalization permit a step-down determination based solely on the absence of imminent risk, or are additional clinical factors — such as functional impairment, environmental barriers, and treatment goal completion — also required to be assessed?
- What specific documentation, if provided now, would lead you to overturn or modify this determination?

Close these gaps before the call

- ☐ Obtain the full adverse-benefit determination notice (the record contains only a provider-summarized excerpt) to confirm the operative denial codes, exact denial date, expedited appeal instructions, and whether additional appeal deadlines apply.
- ☐ Obtain the identity, licensure type, and clinical specialty of the Optum reviewer who issued this determination before the P2P call if possible.
- ☐ Obtain the full Optum Behavioral Clinical Policy for partial hospitalization, including version number and effective date, cited in the denial.

- ☐ Prepare a treating clinician-signed letter of medical necessity documenting current symptom severity, functional impairment, active treatment goals not yet achieved, the home-environment safety barrier, the medication titration timeline, and the team's explicit step-down readiness criteria with rationale for why they have not been met.
- ☐ Obtain formal risk assessment documentation that captures subacute and chronic risk factors beyond imminent dangerousness, including the stockpiled-medication incident and its resolution.
- ☐ Document any history of prior lower-level-of-care treatment (IOP or outpatient) and outcomes; if a prior IOP attempt was unsuccessful, that history directly counters the claim that IOP is currently sufficient. This history is not found in the record as supplied.
- ☐ Confirm with the plan whether the peer-to-peer review window is still open given that the 1-business-day window initially offered was missed by the attending psychiatrist, and whether an extension or new window can be scheduled.

Timing

The provider reported 30 calendar days remaining as of Monday, October 19, 2026, placing the working appeal deadline at Wednesday, November 18, 2026. Confirm this date against the full denial notice when obtained. Because the member is in active treatment, confirm immediately with Optum whether an expedited appeal or a new peer-to-peer window is available and what the deadline is to request each.

ClaimParrot drafts appeal materials for review by your team. It is not a law firm, does not give legal or medical advice, and does not guarantee an outcome. A qualified clinician and your billing team must verify every fact, deadline and clinical statement before anything is submitted.