LEVEL 2 CLINICAL MEDICAL NECESSITY, CMS NCCI & FEDERAL ERISA § 503 STATUTORY APPEAL PACKET

Submitting Provider / RCM Entity: Cumberland Valley Ambulatory Surgery & Orthopedic Institute
Statutory Authorities Invoked: 29 U.S.C. § 1133 (ERISA § 503) | 29 CFR § 2560.503-1(h)(3)(iii) | CMS NCCI Policy Manual | State Prompt-Pay Interest Statutes (TN TCA § 56-7-109, TX Ins. Code Ch. 843/1301, GA OCGA § 33-24-59.5, FL Stat. § 627.6131)
Packet Generation Timestamp: 2026-10-24 16:07:10 UTC | **HIPAA Zero-Leak SHA-256 Digest:** `799c6c26a408a3efb45efedb02c66718...`

CLAIM ID	PATIENT	PAYER	CPT / ICD-10	CARC	BILLED	CONTRACTED	PAID	DEMAND ($)
CLM-2026-884101	Evelyn R. Vance	UnitedHealthcare Comme	27447 / M17.11	CO-50	$58,000	$38,400	$0	$38,400.00
CLM-2026-884102	Marcus T. Sterling	BlueCross BlueShield o	63030 / M51.16	CO-197	$49,500	$33,250	$0	$33,250.00
CLM-2026-884103	Harrison G. Caldwell	Aetna Signature Admini	22612 / M48.061	CO-50	$68,000	$44,800	$0	$44,800.00
CLM-2026-884104	Clara M. Kensington	Cigna Health and Life	29881 / M23.211	CO-97	$26,400	$19,500	$3,100	$16,400.00
CLM-2026-884105	Arthur J. Pendelton	UnitedHealthcare Choic	29827 / M75.121	CO-45	$34,800	$26,900	$5,400	$21,500.00
CLM-2026-884106	Diana L. Whitmore	BlueCross BlueShield (	62323 / M54.16	PR-204	$18,500	$12,800	$0	$12,800.00
CLM-2026-884107	Raymond K. Mercer	Aetna Commercial POS I	43239 / K21.00	CO-29	$16,200	$11,400	$0	$11,400.00
CLM-2026-884108	Victoria S. Hawthorne	Cigna PPO / Administra	99215 / M17.12	CO-97	$9,200	$7,300	$1,200	$6,100.00
TOTALS	**8 Claims**	**Multi-Payer Batch**	**—**	**—**	**$280,600.00**	**$194,350.00**	**$9,700.00**	**$184,650.00**

CLAIM APPEAL DOSSIER #1: CLM-2026-884101 — Evelyn R. Vance (UnitedHealthcare Commercial PPO)

Member ID: MBR-UHC-9948210 | **MRN:** MRN-ASC-44019 | **Rendering NPI:** 1841290482 | **Date of Service:** 2026-09-14
Surgical Procedure: CPT 27447 — Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (Total Knee Arthroplasty)
Primary Diagnosis: ICD-10-CM M17.11 — Unilateral primary osteoarthritis, right knee
Denial / Underpayment Code: CARC CO-50 (Non-Covered Service / Deemed Not Medically Necessary) | RARC N115
Billed Charge: $58,000.00 | **Contracted ASC Allowed Rate:** $38,400.00 | **Actual Paid:** $0.00 | **Principal Underpayment Demand:** **$38,400.00** (+ $864.00 Statutory Prompt-Pay Interest @ 18.0% APR = **$39,264.00 Total Demand**)

I. FEDERAL ERISA § 503 (29 U.S.C. § 1133) & 29 CFR § 2560.503-1 STATUTORY DEMAND:
DEMAND UNDER ERISA § 503 (29 U.S.C. § 1133) & 29 CFR § 2560.503-1(h)(3)(iii)-(iv): Payer issued an adverse benefit determination alleging lack of medical necessity (CARC CO-50). Pursuant to 29 CFR § 2560.503-1(h)(3)(iii), in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the Plan Fiduciary MUST consult with a health care professional who has appropriate training and experience in the exact field of medicine involved (Board-Certified Subspecialist) and who was neither consulted in connection with the initial denial nor the subordinate of any such individual. Furthermore, under 29 CFR § 2560.503-1(m)(8), Payer is legally compelled within 30 days to produce: (1) the complete internal clinical policy/guideline relied upon; (2) the name, NPI, and board certification of the reviewing clinician; and (3) all automated/algorithmic batch-scoring logs (including Optum/NaviHealth/Cigna pxDx batch review audit trails).

II. PEER-REVIEWED CLINICAL MEDICAL NECESSITY & CMS NCCI CODING AUTHORITY:
• *Clinical Guideline:* AAOS Clinical Practice Guideline on Management of Osteoarthritis of the Knee (3rd Ed.) & CMS Local Coverage Determination (LCD L35936): Radiographic Kellgren-Lawrence Grade IV bone-on-bone joint space obliteration with severe functional impairment and documented failure of non-operative multimodal therapy (>90 days NSAIDs, physical therapy, and intra-articular corticosteroid viscodepletion) satisfies absolute clinical criteria for primary Total Knee Arthroplasty.
• *CMS NCCI / Modifier Justification:* CMS NCCI Policy Manual Ch. 4 § E: Primary TKA (CPT 27447) is a standalone major joint arthroplasty procedure; payer bundling or downcoding to partial arthroplasty (27446) violates CPT statutory descriptor definitions.

III. MANDATORY STATE PROMPT-PAY STATUTORY INTEREST DEMAND (Tennessee Code Annotated (TCA) § 56-7-109 (Prompt Pay Act)):
Pursuant to Tennessee Code Annotated (TCA) § 56-7-109(b)(1)(A), health insurance entities must pay or deny 90% of clean

electronic claims within twenty-one (21) calendar days of receipt, and 99.5% within sixty (60) calendar days. Any claim not timely paid in full in accordance with the contracted fee schedule accrues mandatory statutory interest at ONE AND ONE-HALF PERCENT (1.5%) PER MONTH (18.0% APR) from the 22nd day post-submission until paid in full, enforced by the Tennessee Department of Commerce and Insurance (TDCI).

CLAIM APPEAL DOSSIER #2: CLM-2026-884102 — Marcus T. Sterling (BlueCross BlueShield of Tennessee)

Member ID: MBR-BCBS-7731904 | **MRN:** MRN-ASC-44028 | **Rendering NPI:** 1922048193 | **Date of Service:** 2026-09-16
Surgical Procedure: CPT 63030 — Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
Primary Diagnosis: ICD-10-CM M51.16 — Intervertebral disc disorders with radiculopathy, lumbar region
Denial / Underpayment Code: CARC CO-197 (Precertification / Prior Authorization / Notification Absent) | RARC M62
Billed Charge: $49,500.00 | **Contracted ASC Allowed Rate:** $33,250.00 | **Actual Paid:** $0.00 | **Principal Underpayment Demand: $33,250.00** (+ $748.12 Statutory Prompt-Pay Interest @ 18.0% APR = **$33,998.12 Total Demand**)

I. FEDERAL ERISA § 503 (29 U.S.C. § 1133) & 29 CFR § 2560.503-1 STATUTORY DEMAND:
RETROACTIVE PRIOR AUTHORIZATION & URGENT CARE EXCEPTION DEMAND (29 CFR § 2560.503-1(f)(2) & ACA § 2719A): Payer denied surgical reimbursement solely on an administrative technicality (CARC CO-197) despite documented clinical urgency and/or prior surgical intake notification. Under 29 CFR § 2560.503-1(b)(3), employee benefit plans are prohibited from administering claims procedures in a way that inhibits or hampers the initiation or processing of claims, and cannot forfeit substantive surgical benefits where clinical necessity is undisputed.

II. PEER-REVIEWED CLINICAL MEDICAL NECESSITY & CMS NCCI CODING AUTHORITY:
• *Clinical Guideline:* North American Spine Society (NASS) Evidence-Based Clinical Guidelines for Lumbar Disc Herniation with Radiculopathy & CMS LCD L34976: MRI-confirmed extruded/sequestered lumbar nucleus pulposus compressing the traversing nerve root with concordant dermatomal motor weakness (<=4/5 dorsiflexion) and positive straight-leg raise constitutes an urgent surgical decompression indication.
• *CMS NCCI / Modifier Justification:* CMS NCCI Policy Manual Ch. 8: Microdiscectomy decompression at L4-L5 (CPT 63030) includes approach and neural elements decompression; retroactive prior-authorization denial on urgent progressive motor radiculopathy violates 29 CFR § 2560.503-1(m)(4).

III. MANDATORY STATE PROMPT-PAY STATUTORY INTEREST DEMAND (Tennessee Code Annotated (TCA) § 56-7-109 (Prompt Pay Act)):
Pursuant to Tennessee Code Annotated (TCA) § 56-7-109(b)(1)(A), health insurance entities must pay or deny 90% of clean electronic claims within twenty-one (21) calendar days of receipt, and 99.5% within sixty (60) calendar days. Any claim not timely paid in full in accordance with the contracted fee schedule accrues mandatory statutory interest at ONE AND ONE-HALF PERCENT (1.5%) PER MONTH (18.0% APR) from the 22nd day post-submission until paid in full, enforced by the Tennessee Department of Commerce and Insurance (TDCI).

CLAIM APPEAL DOSSIER #3: CLM-2026-884103 — Harrison G. Caldwell (Aetna Signature Administrators PPO)

Member ID: MBR-AET-6610492 | **MRN:** MRN-ASC-44055 | **Rendering NPI:** 1750391847 | **Date of Service:** 2026-09-18
Surgical Procedure: CPT 22612 — Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)
Primary Diagnosis: ICD-10-CM M48.061 — Spinal stenosis, lumbar region without neurogenic claudication
Denial / Underpayment Code: CARC CO-50 (Non-Covered Service / Deemed Not Medically Necessary) | RARC N386
Billed Charge: $68,000.00 | **Contracted ASC Allowed Rate:** $44,800.00 | **Actual Paid:** $0.00 | **Principal Underpayment Demand: $44,800.00** (+ $1,008.00 Statutory Prompt-Pay Interest @ 18.0% APR = **$45,808.00 Total Demand**)

I. FEDERAL ERISA § 503 (29 U.S.C. § 1133) & 29 CFR § 2560.503-1 STATUTORY DEMAND:
DEMAND UNDER ERISA § 503 (29 U.S.C. § 1133) & 29 CFR § 2560.503-1(h)(3)(iii)-(iv): Payer issued an adverse benefit determination alleging lack of medical necessity (CARC CO-50). Pursuant to 29 CFR § 2560.503-1(h)(3)(iii), in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the Plan Fiduciary MUST consult with a health care professional who has appropriate training and experience in the exact field of medicine involved (Board-Certified Subspecialist) and who was neither consulted in connection with the initial denial nor the subordinate of any such individual. Furthermore, under 29 CFR § 2560.503-1(m)(8), Payer is legally compelled within 30 days to produce: (1) the complete internal

clinical policy/guideline relied upon; (2) the name, NPI, and board certification of the reviewing clinician; and (3) all automated/algorithmic batch-scoring logs (including Optum/NaviHealth/Cigna pxDx batch review audit trails).

II. PEER-REVIEWED CLINICAL MEDICAL NECESSITY & CMS NCCI CODING AUTHORITY:
• *Clinical Guideline:* NASS Coverage Policy Recommendations for Lumbar Spinal Fusion & AAOS Spine Guidelines: Dynamic flexion-extension radiographs demonstrating >4mm translational spondylolisthesis or >10 degrees angular instability coupled with severe central/foraminal stenosis (ICD-10 M48.061) establishes Level-1A medical necessity for posterolateral lumbar arthrodesis (CPT 22612).
• *CMS NCCI / Modifier Justification:* CMS NCCI Policy Manual Ch. 4: Posterior arthrodesis (CPT 22612) is separately reportable from instrumentation (22840) and biomechanical device insertion; algorithmic medical necessity denial without board-certified spine surgeon review violates 29 CFR § 2560.503-1(h)(3)(iii).

III. MANDATORY STATE PROMPT-PAY STATUTORY INTEREST DEMAND (Texas Insurance Code Ch. 843 (§ 843.342) & Ch. 1301 (§ 1301.103 / § 1301.137)):
Pursuant to Texas Insurance Code §§ 843.338 and 1301.103, a preferred provider carrier or HMO must adjudicate and pay clean electronic claims within thirty (30) calendar days. Under §§ 843.342 and 1301.137, an insurer that fails to pay the full contracted rate within the statutory period is liable for graduated statutory penalties (50% to 100% of the difference between billed charges and the contracted rate) PLUS 18.0% PER ANNUM statutory interest on the penalty amount.

CLAIM APPEAL DOSSIER #4: CLM-2026-884104 — Clara M. Kensington (Cigna Health and Life Insurance (OAP))

Member ID: MBR-CIG-5529108 | **MRN:** MRN-ASC-44081 | **Rendering NPI:** 1841290482 | **Date of Service:** 2026-09-19
Surgical Procedure: CPT 29881 — Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty)
Primary Diagnosis: ICD-10-CM M23.211 — Derangement of anterior horn of medial meniscus due to old tear or injury, right knee
Denial / Underpayment Code: CARC CO-97 (Improper NCCI Bundling / Payment Included in Allowance for Another Service) | RARC M80
Billed Charge: $26,400.00 | **Contracted ASC Allowed Rate:** $19,500.00 | **Actual Paid:** $3,100.00 | **Principal Underpayment Demand:** **$16,400.00** (+ $246.00 Statutory Prompt-Pay Interest @ 12.0% APR = **$16,646.00 Total Demand**)

I. FEDERAL ERISA § 503 (29 U.S.C. § 1133) & 29 CFR § 2560.503-1 STATUTORY DEMAND:
CMS NATIONAL CORRECT CODING INITIATIVE (NCCI) MODIFIER-59 / XU / 25 UNBUNDLING DEMAND & ERISA § 503 NOTICE: Payer improperly bundled a distinct anatomical compartment or unrelated contralateral service under CARC CO-97. Under the CMS NCCI Policy Manual and AMA CPT Modifier-59 / Modifier-XU / Modifier-25 guidelines, procedures performed in a separate anatomical compartment, separate incision/lesion, or unrelated contralateral extremity during a global period are independently reimbursable. Automated software scrubbing that strips valid Modifiers 59, XU, 24, or 25 without operative-report review constitutes an arbitrary and capricious fiduciary breach under 29 U.S.C. § 1132(a)(1)(B).

II. PEER-REVIEWED CLINICAL MEDICAL NECESSITY & CMS NCCI CODING AUTHORITY:
• *Clinical Guideline:* AAOS Clinical Practice Guideline for Acute Isolated Meniscal Pathology & Arthroscopy Association of North America (AANA) Criteria: Mechanical locking, catching, and MRI-verified displaced bucket-handle/complex tear of the medial meniscus anterior horn (ICD-10 M23.211) unresponsive to mechanical unloading requires arthroscopic meniscectomy (CPT 29881).
• *CMS NCCI / Modifier Justification:* CMS NCCI Policy Manual Ch. 4 § E & Modifier-59 / XU Distinct Procedural Service Mandate: When arthroscopic intervention or diagnostic/therapeutic work is performed across anatomically separate compartments (Medial vs. Lateral/Patellofemoral), Modifier 59 / XU overrides automated NCCI Column-2 bundling.

III. MANDATORY STATE PROMPT-PAY STATUTORY INTEREST DEMAND (Official Code of Georgia Annotated (OCGA) § 33-24-59.5 (Georgia Prompt Pay Act)):
Pursuant to Official Code of Georgia Annotated (OCGA) § 33-24-59.5(b)(1), insurers and third-party administrators (TPAs) must remit payment on clean electronic healthcare claims within fifteen (15) working days of electronic receipt. Failure to remit the full payable benefit within 15 working days mandates automatic statutory interest at TWELVE PERCENT (12.0% to 18.0%) PER ANNUM transferred directly to the healthcare provider.

CLAIM APPEAL DOSSIER #5: CLM-2026-884105 — Arthur J. Pendelton (UnitedHealthcare Choice Plus)

Member ID: MBR-UHC-3391045 | **MRN:** MRN-ASC-44102 | **Rendering NPI:** 1689742015 | **Date of Service:** 2026-09-22
Surgical Procedure: CPT 29827 — Arthroscopy, shoulder, surgical; with rotator cuff repair
Primary Diagnosis: ICD-10-CM M75.121 — Complete rotator cuff tear or rupture of right shoulder, not specified as traumatic

Denial / Underpayment Code: CARC CO-45 (Charge Exceeds Fee Schedule / Contracted Rate Underpayment Variance) | RARC N381
Billed Charge: $34,800.00 | **Contracted ASC Allowed Rate:** $26,900.00 | **Actual Paid:** $5,400.00 | **Principal Underpayment Demand: $21,500.00** (+ $322.50 Statutory Prompt-Pay Interest @ 12.0% APR = **$21,822.50 Total Demand**)

I. FEDERAL ERISA § 503 (29 U.S.C. § 1133) & 29 CFR § 2560.503-1 STATUTORY DEMAND:
BREACH OF PARTICIPATING PROVIDER / ASC FACILITY FEE SCHEDULE & ERISA PLAN RATE DEMAND (29 U.S.C. § 1132(a)(1)(B)): Payer adjudicated this surgical claim at an unauthorized discount/Out-of-Network repricing benchmark under CARC CO-45, resulting in a direct contractual underpayment below the executed Participating Provider / ASC Master Group Fee Schedule. Pursuant to 29 CFR § 2560.503-1(g)(1)(v)(A), Payer must disclose the exact pricing methodology, grouper table, and third-party repricer (MultiPlan/Data iSight/Viant) calculation sheet within 30 days and remit the full Contracted Allowed Rate variance immediately.

II. PEER-REVIEWED CLINICAL MEDICAL NECESSITY & CMS NCCI CODING AUTHORITY:
• *Clinical Guideline:* AAOS Clinical Practice Guideline on Management of Rotator Cuff Injuries (Strong Recommendation): Full-thickness supraspinatus/infraspinatus tendon tear (ICD-10 M75.121) confirmed on 3T MRI with persistent pain and abduction weakness requires arthroscopic suture-anchor rotator cuff repair (CPT 29827).
• *CMS NCCI / Modifier Justification:* CMS ASC Payment System & Participating Provider Agreement Group Grouper Schedule: CPT 29827 must be reimbursed at the bilateral contracted In-Network ASC Case Rate; unilateral repricing to Out-of-Network Medicare percentage violates the Master Participating Facility Agreement.

III. MANDATORY STATE PROMPT-PAY STATUTORY INTEREST DEMAND (Florida Statute § 627.6131 (Payment of Health Claims)):
Pursuant to Florida Statute § 627.6131(4)(a), health insurers must pay or contest electronic clean claims within twenty (20) calendar days after receipt. Under § 627.6131(7), all overdue payments bear mandatory simple statutory interest at TWELVE PERCENT (12.0%) PER YEAR, which cannot be waived by any provider contract.

CLAIM APPEAL DOSSIER #6: CLM-2026-884106 — Diana L. Whitmore (BlueCross BlueShield (BlueCard PPO))

Member ID: MBR-BCBS-8820147 | **MRN:** MRN-ASC-44119 | **Rendering NPI:** 1922048193 | **Date of Service:** 2026-09-25
Surgical Procedure: CPT 62323 — Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e., fluoroscopy or CT)
Primary Diagnosis: ICD-10-CM M54.16 — Radiculopathy, lumbar region
Denial / Underpayment Code: CARC PR-204 (Service Not Covered Under Current Plan Benefit / Shifted to Patient) | RARC N130
Billed Charge: $18,500.00 | **Contracted ASC Allowed Rate:** $12,800.00 | **Actual Paid:** $0.00 | **Principal Underpayment Demand: $12,800.00** (+ $288.00 Statutory Prompt-Pay Interest @ 18.0% APR = **$13,088.00 Total Demand**)

I. FEDERAL ERISA § 503 (29 U.S.C. § 1133) & 29 CFR § 2560.503-1 STATUTORY DEMAND:
ERISA § 104(b)(4) (29 U.S.C. § 1024(b)(4)) PLAN DOCUMENT DEMAND & IMPROPER PATIENT COST-SHIFTING REBUTTAL: Payer improperly shifted a medically necessary interventional procedure to Patient Responsibility under CARC PR-204 despite active surgical/outpatient coverage verified via ANSI X12 270/271 Eligibility & Benefit Inquiry prior to surgery. Pursuant to ERISA § 104(b)(4) and § 502(c)(1), we demand production of the full Summary Plan Description (SPD) and Master Plan Document proving an explicit exclusion; failure to produce within 30 days triggers statutory penalties of up to $110 per day.

II. PEER-REVIEWED CLINICAL MEDICAL NECESSITY & CMS NCCI CODING AUTHORITY:
• *Clinical Guideline:* American Society of Interventional Pain Physicians (ASIPP) Evidence-Based Guidelines & CMS LCD L39015: Fluoroscopically guided lumbar interlaminar epidural steroid injection with contrast epidurogram (CPT 62323) is a covered first-line interventional therapy for acute/subacute lumbar radiculopathy (ICD-10 M54.16).
• *CMS NCCI / Modifier Justification:* CMS NCCI Policy Manual Ch. 8: Fluoroscopic guidance is bundled into 62323; shifting covered interventional spine procedures to Patient Responsibility (PR-204) contravenes the Summary Plan Description (SPD) Surgical & Interventional Pain Benefit Schedule.

III. MANDATORY STATE PROMPT-PAY STATUTORY INTEREST DEMAND (Tennessee Code Annotated (TCA) § 56-7-109 (Prompt Pay Act)):
Pursuant to Tennessee Code Annotated (TCA) § 56-7-109(b)(1)(A), health insurance entities must pay or deny 90% of clean electronic claims within twenty-one (21) calendar days of receipt, and 99.5% within sixty (60) calendar days. Any claim not timely paid

in full in accordance with the contracted fee schedule accrues mandatory statutory interest at ONE AND ONE-HALF PERCENT (1.5%) PER MONTH (18.0% APR) from the 22nd day post-submission until paid in full, enforced by the Tennessee Department of Commerce and Insurance (TDCI).

CLAIM APPEAL DOSSIER #7: CLM-2026-884107 — Raymond K. Mercer (Aetna Commercial POS II)

Member ID: MBR-AET-1194823 | **MRN:** MRN-ASC-44140 | **Rendering NPI:** 1538294011 | **Date of Service:** 2026-09-28
Surgical Procedure: CPT 43239 — Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple
Primary Diagnosis: ICD-10-CM K21.00 — Gastro-esophageal reflux disease with esophagitis, without bleeding
Denial / Underpayment Code: CARC CO-29 (Time Limit for Filing Has Expired (Timely Filing Denial)) | RARC N211
Billed Charge: $16,200.00 | **Contracted ASC Allowed Rate:** $11,400.00 | **Actual Paid:** $0.00 | **Principal Underpayment Demand:** **$11,400.00** (+ $256.50 Statutory Prompt-Pay Interest @ 18.0% APR = **$11,656.50 Total Demand**)

I. FEDERAL ERISA § 503 (29 U.S.C. § 1133) & 29 CFR § 2560.503-1 STATUTORY DEMAND:
PROOF OF TIMELY ELECTRONIC EDI 837 SUBMISSION & STATUTORY WAIVER DEMAND: Payer wrongfully denied this claim under CARC CO-29 (Timely Filing). Provider possesses timestamped ANSI X12 277CA Electronic Clearinghouse Acceptance Receipts and Payer Portal Scrub Logs confirming original electronic submission well within the contractual 90/180-day filing window. Under state insurance regulations and federal ERISA fiduciary standards, an accepted 277CA electronic transmission legally tolls the timely filing clock.

II. PEER-REVIEWED CLINICAL MEDICAL NECESSITY & CMS NCCI CODING AUTHORITY:
• *Clinical Guideline:* American Society for Gastrointestinal Endoscopy (ASGE) Standards of Practice & ACG Guidelines for GERD/Dysphagia: Diagnostic and therapeutic upper GI endoscopy with mucosal biopsy (CPT 43239) is medically required for erosive esophagitis (ICD-10 K21.00) to exclude Barrett's metaplasia/dysplasia.
• *CMS NCCI / Modifier Justification:* ASC Electronic EDI 837P/837I Clearinghouse Rule: An ANSI X12 277CA Claim Acknowledgment Status Category 'A1/A2' (Accepted into Payer Adjudication System) conclusively defeats a CARC CO-29 Timely Filing denial as a matter of state and federal contract law.

III. MANDATORY STATE PROMPT-PAY STATUTORY INTEREST DEMAND (Texas Insurance Code Ch. 843 (§ 843.342) & Ch. 1301 (§ 1301.103 / § 1301.137)):
Pursuant to Texas Insurance Code §§ 843.338 and 1301.103, a preferred provider carrier or HMO must adjudicate and pay clean electronic claims within thirty (30) calendar days. Under §§ 843.342 and 1301.137, an insurer that fails to pay the full contracted rate within the statutory period is liable for graduated statutory penalties (50% to 100% of the difference between billed charges and the contracted rate) PLUS 18.0% PER ANNUM statutory interest on the penalty amount.

CLAIM APPEAL DOSSIER #8: CLM-2026-884108 — Victoria S. Hawthorne (Cigna PPO / Administrative Services Only (ERISA ASO))

Member ID: MBR-CIG-4401928 | **MRN:** MRN-ASC-44163 | **Rendering NPI:** 1841290482 | **Date of Service:** 2026-09-30
Surgical Procedure: CPT 99215 — Office or other outpatient visit for the evaluation and management of an established patient, requiring high-level medical decision making (MDM) or 40-54 minutes total time
Primary Diagnosis: ICD-10-CM M17.12 — Unilateral primary osteoarthritis, left knee
Denial / Underpayment Code: CARC CO-97 (Improper NCCI Bundling / Payment Included in Allowance for Another Service) | RARC M144
Billed Charge: $9,200.00 | **Contracted ASC Allowed Rate:** $7,300.00 | **Actual Paid:** $1,200.00 | **Principal Underpayment Demand:** **$6,100.00** (+ $137.25 Statutory Prompt-Pay Interest @ 18.0% APR = **$6,237.25 Total Demand**)

I. FEDERAL ERISA § 503 (29 U.S.C. § 1133) & 29 CFR § 2560.503-1 STATUTORY DEMAND:
CMS NATIONAL CORRECT CODING INITIATIVE (NCCI) MODIFIER-59 / XU / 25 UNBUNDLING DEMAND & ERISA § 503 NOTICE: Payer improperly bundled a distinct anatomical compartment or unrelated contralateral service under CARC CO-97. Under the CMS NCCI Policy Manual and AMA CPT Modifier-59 / Modifier-XU / Modifier-25 guidelines, procedures performed in a separate anatomical compartment, separate incision/lesion, or unrelated contralateral extremity during a global period are independently reimbursable. Automated software scrubbing that strips valid Modifiers 59, XU, 24, or 25 without operative-report review constitutes an arbitrary and capricious fiduciary breach under 29 U.S.C. § 1132(a)(1)(B).

II. PEER-REVIEWED CLINICAL MEDICAL NECESSITY & CMS NCCI CODING AUTHORITY:
• *Clinical Guideline:* AMA CPT Evaluation & Management (E&M;) Guidelines (2024/2026 Revision): High-complexity medical decision making (CPT 99215) involving acute contralateral joint pathology (ICD-10 M17.12) and prescription/parenteral risk management is separately identifiable from any contralateral global surgical period.

• *CMS NCCI / Modifier Justification:* CMS NCCI Policy Manual Ch. 1 § C & Modifier-24 / Modifier-25 Mandate: Evaluation and management of an unrelated contralateral condition (Left Knee M17.12 during Right Knee post-op global window) appended with Modifier 24/25 is statutorily exempt from global surgical package bundling (CARC CO-97).

III. MANDATORY STATE PROMPT-PAY STATUTORY INTEREST DEMAND (Tennessee Code Annotated (TCA) § 56-7-109 (Prompt Pay Act)):

Pursuant to Tennessee Code Annotated (TCA) § 56-7-109(b)(1)(A), health insurance entities must pay or deny 90% of clean electronic claims within twenty-one (21) calendar days of receipt, and 99.5% within sixty (60) calendar days. Any claim not timely paid in full in accordance with the contracted fee schedule accrues mandatory statutory interest at ONE AND ONE-HALF PERCENT (1.5%) PER MONTH (18.0% APR) from the 22nd day post-submission until paid in full, enforced by the Tennessee Department of Commerce and Insurance (TDCI).

HIPAA SAFE HARBOR (45 CFR § 164.514(b)(2)) ZERO-LEAK CRYPTOGRAPHIC AUDIT CERTIFICATE

This certificate attests that prior to any hybrid clinical or statutory appeal synthesis, all 18 HIPAA Safe Harbor Protected Health Information (PHI) identifiers within this remittance batch were deterministically intercepted and tokenized on-premise in **<5 milliseconds** on standard CPU hardware with **0.00% external PHI egress**.

HIPAA SAFE HARBOR TELEMETRY METRIC	CRYPTOGRAPHIC VERIFICATION VALUE
Compliance Standard	45 CFR § 164.514(b)(2) HIPAA Safe Harbor + HITECH § 13402
Hardware Execution Profile	100% Standard CPU-Native (0% GPU Required)
PHI Vault Tokenization Latency	2.566 ms (<5.0 ms SLA)
Total PHI Entities Intercepted & Tokenized	164 Entities
Unique Reversible Vault Tokens Created	81 Tokens
Token Categories Redacted	PATIENT, MEMBER_ID, MRN, SSN, NPI, CLAIM, DOS, AMOUNT
Outbound Payload SHA-256 Digest	799c6c26a408a3efb45efedb02c667185a6d4239268b0cba75102de6da4bbcf1
Corporate Compliance Desk	contact@diggitaloasis.com | https://diggitaloasis.com/revrecover/
Zero-Leak Attestation Status	**VERIFIED — 0% RAW PHI TRANSMITTED OUTSIDE LOCAL PERIMETER**

Sanitized Outbound Firewall Payload Excerpt (0% PHI):

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ELECTRONIC REMITTANCE ADVICE (ERA / ANSI X12 835) & EXPLANATION OF
BENEFITS — PAGE 1 OF 3 (ORTHOPEDIC RECONSTRUCTION & SPINE SURGERY)
Rendering Facility: Cumberland Valley Ambulatory Surgery & Orthopedic Institute | Tax ID: 62-1849201 | Batch ID:
BATCH-ASC-2026-1024 | Clearinghouse: Availity EDI 835 Gateway
CLAIM #1: [CLAIM_1] — UnitedHealthcare Commercial PPO (TN) — CARC CO-50
Claim ID: [CLAIM_1] | Patient: [PATIENT_1] | Member ID: [MEMBER_ID_1]
MRN: [MRN_1] | SSN: [SSN_1] | NPI: [NPI_1] | DOS: [DOS_1]
Payer: UnitedHealthcare Commercial PPO | State: TN
CPT: 27447 (Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with )
ICD-10: M17.11 (Unilateral primary osteoarthritis, right knee)
CARC: CO-50 (Non-Covered Service / Deemed Not Medically Necessary) | RARC: N115
Billed Amount: [AMOUNT_1] | Contracted Allowed Rate: [AMOUNT_2] | Actual Paid Amount: [AMOUNT_3]
Net Recoverable Variance: [AMOUNT_2]
[CLAIM_2] Name
Member ID
CPT / ICD-10
CARC / RARC
Billed ($)
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