Common Denial Reasons & Appeal Language

Eight GLP-1 prior authorization denial scenarios — each with root cause analysis, a ready-to-adapt appeal paragraph, and a documentation checklist.

Adapt every template to the individual patient. Do not copy verbatim.

How to use this guide: Find the denial reason that matches your situation. Read the root cause, then use the appeal language template as a starting point. Fill in all green italic bracketed fields with patient-specific information. Attach supporting documents as listed. Every appeal is stronger when individualized.

DENIAL SCENARIO 1

Wrong or Unspecified ICD-10 Code

What the denial typically says:

"The prior authorization request was denied because the submitted diagnosis code does not meet criteria for coverage of this medication. Please resubmit with the appropriate diagnosis code."

ROOT CAUSE

E66.9 (obesity, unspecified) was used instead of a specific code. Most payers require E66.01 (morbid obesity due to excess calories) or E66.09 (other obesity due to excess calories). Unspecified codes are routinely rejected.

WHAT TO FIX

- Use E66.01 for BMI □ 40, or BMI □ 35 with comorbidity
- Use E66.09 for BMI 30–39.9
- Add a Z68.3x–Z68.4x BMI code at the same visit
- Pair with at least one comorbidity code (E11.x, I10, G47.33, etc.)

APPEAL LANGUAGE TEMPLATE

We are resubmitting the prior authorization for [Patient Name] with the corrected primary diagnosis. The original submission used an unspecified obesity code. The correct code for this patient is [E66.01 / E66.09], reflecting a BMI of [##.#] documented at the [Date] visit. The corresponding BMI range code [Z68.xx] and comorbidity codes [list codes] have been added to this resubmission. Please find the updated clinical note attached.

ATTACH TO APPEAL:

- ■ Corrected claim with specific ICD-10 code (E66.01 or E66.09) and Z68 BMI code
- ■ Current visit note with documented weight, height, and calculated BMI
- ■ Comorbidity documentation if applicable

DENIAL SCENARIO 2

BMI Not Documented at Time of Service

What the denial typically says:

"Authorization has been denied. The submitted records do not include documentation of the patient's BMI at the time of the requested service."

ROOT CAUSE

The Z68 BMI code was omitted from the claim, or the clinical note did not include documented height, weight, and calculated BMI at that specific encounter. Some payers require BMI in the note body, not just as a billing code.

WHAT TO FIX

- Add Z68.3x or Z68.4x BMI code matching today's visit
- Document weight, height, and calculated BMI in the visit note itself
- Use current measurements — a prior visit's BMI is often insufficient
- Include BMI in the Assessment/Plan section, not only the vitals header

APPEAL LANGUAGE TEMPLATE

We are appealing the denial regarding missing BMI documentation for [Patient Name]. The patient's current BMI of [##.#], based on a documented weight of [###] lbs and height of [##'##"], was recorded at the [Date] visit. The corresponding ICD-10 BMI code [Z68.xx] has been added to the resubmission. Please see the attached clinical note confirming this measurement.

ATTACH TO APPEAL:

- ■ Visit note with documented weight, height, and BMI at time of service
- ■ Corrected claim with Z68 BMI code added

DENIAL SCENARIO 3

Obesity-Related Comorbidity Not Documented

What the denial typically says:

"Prior authorization has been denied. The patient's records do not demonstrate an obesity-related comorbidity required for coverage of this medication class."

ROOT CAUSE

The claim did not include a comorbidity code alongside the obesity diagnosis, or comorbidities were mentioned in the note but not coded. Most payers require at least one comorbidity — T2DM, HTN, dyslipidemia, OSA, NAFLD, or osteoarthritis.

WHAT TO FIX

- Add all active comorbidity ICD-10 codes to the claim
- Document the clinical impact of each comorbidity in the note
- If T2DM is present, E11.x may allow coverage under the T2DM indication
- Ensure comorbidities appear in both the note and on the ICD-10 code list

APPEAL LANGUAGE TEMPLATE

We are resubmitting the authorization for [Patient Name] with additional comorbidity documentation. The patient carries active diagnoses of [list comorbidities with ICD-10 codes], which directly contribute to the clinical picture and support the medical necessity of GLP-1 therapy. These conditions are documented in the attached clinical note and have been added to this resubmission.

ATTACH TO APPEAL:

- ■ Updated claim with comorbidity ICD-10 codes added
- ■ Clinical note documenting each active comorbidity
- ■ Relevant labs or specialist notes (HbA1c, sleep study, lipid panel, etc.)

DENIAL SCENARIO 4

Step Therapy Requirement Not Met

What the denial typically says:

"Authorization is denied. The member has not demonstrated a trial of a required prior pharmacological therapy as outlined in the plan's formulary criteria."

ROOT CAUSE

The payer requires documented prior failure of a first-line medication — commonly orlistat, phentermine, or naltrexone/bupropion. The submission lacked adequate detail of this trial: drug name, dose, duration, and reason for stopping.

WHAT TO FIX

- Document the prior trial: drug name, dose, start date, end date
- State the specific reason for stopping (intolerance, inadequate response)
- 'Patient refused' is generally insufficient — document the clinical rationale
- If the step drug was contraindicated, document the specific contraindication explicitly

APPEAL LANGUAGE TEMPLATE

[Patient Name] previously trialed [Medication Name] [Dose] from [Start Date] to [End Date]. Therapy was discontinued due to [specific reason — e.g., intolerable GI side effects with orlistat in a patient without consistent restroom access; sympathomimetic conflict in a patient on stimulant therapy for ADHD; tachycardia with phentermine in a patient with pre-existing arrhythmia]. This trial is documented in the attached notes from [prescribing provider / date]. Given this documented prior treatment failure, GLP-1 therapy is the appropriate next step.

ATTACH TO APPEAL:

- ■ Office notes documenting the prior medication trial with dates
- ■ Documentation of reason for discontinuation
- ■ Contraindication documentation if step therapy drug was clinically inappropriate
- ■ Weight trend or lab data showing inadequate response if applicable

DENIAL SCENARIO 5

Lifestyle Intervention Not Adequately Documented

What the denial typically says:

"Prior authorization has been denied. Documentation provided does not meet the requirement for supervised diet and exercise counseling prior to pharmacological intervention."

ROOT CAUSE

Most payers require 3–6 months of documented, supervised lifestyle intervention. Vague language like 'patient was counseled on diet and exercise' is insufficient. The program name, specific dates, type of intervention, and outcome must appear.

WHAT TO FIX

- Name the program (registered dietitian, Weight Watchers, clinic-based counseling)
- Specify start and end dates — duration matters
- Document what was done (dietary changes, calorie targets, exercise regimen)
- Document the outcome: weight change, or the clinical reason the goal was not achieved

APPEAL LANGUAGE TEMPLATE

[Patient Name] participated in [Program Name] from [Start Date] through [End Date] — a [X]-month supervised [dietary / behavioral / combined] intervention. During this period, the patient [achieved X lbs weight loss but plateaued / was unable to achieve sustained weight loss despite documented adherence / lost X% body weight but remains at a BMI requiring pharmacological intervention]. Documentation is attached.

ATTACH TO APPEAL:

- ■ Program records or dietitian notes with visit dates
- ■ Weight log or weigh-in records across the intervention period
- ■ Formal program completion documentation if available

DENIAL SCENARIO 6

Indication Mismatch — Wrong Formulary Category

What the denial typically says:

"This medication is covered under a different benefit category. The submitted diagnosis does not match the approved indication for coverage under this plan."

ROOT CAUSE

GLP-1 agents have different formulary status depending on the indication — T2DM vs. chronic weight management. Semaglutide as Ozempic vs. Wegovy, for example, are the same molecule but different NDCs, different tiers, and different PA pathways. Submitting the wrong NDC routes the request to the wrong reviewer.

WHAT TO FIX

- Verify the NDC matches the intended indication (Ozempic NDC vs. Wegovy NDC)
- If T2DM is present, consider requesting under the T2DM indication first
- Confirm which formulary tier the plan covers the specific NDC under
- Contact the pharmacy benefit manager (PBM) directly if the pathway is unclear

APPEAL LANGUAGE TEMPLATE

We are resubmitting the authorization for [Patient Name] with clarification of the intended clinical indication. The medication is [specific drug name and NDC], prescribed for [T2DM management / chronic weight management] in a patient with active diagnoses of [list diagnoses with ICD-10 codes]. Please review under the [appropriate benefit category / formulary tier].

ATTACH TO APPEAL:

- ■ Corrected PA with the correct NDC and intended indication clearly stated
- ■ Clinical note confirming the intended diagnosis and treatment goals

DENIAL SCENARIO 7

Letter of Medical Necessity Missing or Insufficient

What the denial typically says:

"Authorization cannot be processed. A letter of medical necessity is required and was not submitted, or the letter provided does not address the required clinical criteria."

ROOT CAUSE

Many payers require a formal LMN for GLP-1 approval. Common failures: the letter is generic without individualized clinical detail; it does not address the payer's specific criteria; or it uses vague language ('medication is medically necessary') without clinical support.

WHAT TO FIX

- Use specific clinical detail — BMI, comorbidities, prior treatment history
- Address the payer's stated criteria directly (cite the denial letter)
- Explain why this specific medication is appropriate for this patient
- Avoid generic phrases; support every claim with documented clinical evidence

APPEAL LANGUAGE TEMPLATE

Please find attached a revised letter of medical necessity for [Patient Name] that directly addresses the criteria cited in the denial. The letter documents: (1) current BMI of [##.#] with active comorbidities including [list]; (2) prior lifestyle intervention from [dates and outcome]; (3) prior pharmacological treatment history and reason for discontinuation; and (4) clinical rationale for [specific medication] in this patient.

ATTACH TO APPEAL:

- ■ Revised, individualized letter of medical necessity
- ■ Supporting clinical note addressing each criterion in the denial
- ■ Labs, weight trends, or specialist notes referenced in the LMN

DENIAL SCENARIO 8

Requesting a Peer-to-Peer Review

When to request a peer-to-peer:

A peer-to-peer (P2P) review gives you direct access to the payer's reviewing physician and the opportunity to present the full clinical picture in real time. Written appeals are reviewed by medical directors who may not specialize in obesity medicine — a P2P often resolves denials that survive written appeal. Request one any time a written appeal is upheld.

Request the P2P within the stated timeframe.

Usually 10–14 business days from the denial. Missing this window typically closes the appeal path entirely.

Ask for the reviewer's name and specialty.

You have the right to know who is reviewing. An obesity medicine or endocrinology reviewer will understand the clinical picture differently than a general internist.

Prepare a 2-minute clinical summary.

BMI, active comorbidities, prior lifestyle intervention (dates and outcome), prior medication trials and why they failed or were contraindicated, and why this specific agent is appropriate for this patient.

Reference clinical guidelines by name.

AHA/ACC/TOS obesity treatment guidelines, AACE/ACE obesity algorithm, STEP trials (semaglutide), SURMOUNT trials (tirzepatide). Reviewers respond to guideline-concordant care.

If denied again, ask about IRO review.

An Independent Review Organization review is external, binding, and available in most states after internal appeal is exhausted.

BEFORE THE CALL — HAVE READY:

- ■ Patient's most recent clinical note (BMI, comorbidities, plan)
- ■ Original denial letter — reference the specific criteria cited
- ■ Prior treatment documentation (lifestyle intervention + medication trials)
- ■ Clinical guideline reference (AACE, AHA/ACC, STEP trial data)

DISCLAIMER

Professional Resource — Not a Clinical Protocol or Legal Document

This document is provided for general educational and informational purposes among healthcare professionals. It does not constitute clinical protocols, treatment guidelines, formulary guidance, or legal advice. Prior authorization requirements, covered diagnoses, step therapy criteria, and payer policies vary by plan, formulary, and plan year — always verify current criteria directly with the relevant payer before submitting.

Appeal language templates are examples only. They must be adapted to the individual patient's clinical picture and the provider's professional judgment. Copying appeal language verbatim without individualization is unlikely to succeed.

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