Appeal packet: Medicare Advantage reconsideration request, before care

SAMPLE: made-up case, no real patient. The choices below are made up to show the format. The blanks stay blank.

From (appellant)	[PRACTICE NAME]
Address	[PRACTICE ADDRESS]
Phone / fax	[PHONE] / [FAX]
Responsible physician	[CLINICIAN NAME], [CREDENTIALS]
Patient	[PATIENT NAME], born [DATE OF BIRTH]
Member / beneficiary ID	[MEMBER ID]
Plan	[PLAN NAME] (Medicare Advantage)
Service appealed	neck fusion, back approach (CPT [CPT CODE])
Diagnosis	[DIAGNOSIS]
Denial reference	[DENIAL REFERENCE]
Date of denial	[NOTICE DATE]

Blanks in square brackets are filled by the practice, in its own system, before the physician signs. This packet holds no patient name, birth date, ID number or date.

Row 4 of the criteria table is not shown in the records yet. The physician adds the record and rebuilds the packet, or decides not to send it.

Left out of the plan's table because they apply only in some cases: L39793, exception to the 12 weeks: weakness that is getting worse or limits daily activities; L39793, exception to the 12 weeks: arm pain 7 or more of 10 that limits daily activities, with matching imaging; L39793: instability, a slip of more than 3.5 mm or an angle of more than 11 degrees; L39793: with instability, a substantial limit such as severe neck pain or trouble walking. If one applies to this patient, the physician ticks it and rebuilds the packet before signing.

In this packet

- Reconsideration request from the treating physician
- Criteria table: Medicare coverage rule L39793 and what the records show, marked Shown or Not shown
- Exhibit list: what to pull from the chart, with a page blank for each
- Deadline sheet: the Medicare Advantage time rules in words, with blanks
- One-page peer-to-peer brief
- Physician review and signature

  This packet is built from templates and the choices the practice made. No AI model read or wrote any part of it. Nothing leaves the practice until the named physician has reviewed and signed it.

This packet is not a substitute for the advice of an attorney.

Request for reconsideration, before care

[DATE SENT]

To: Reconsiderations, [PLAN NAME] (Medicare Advantage), fax [PLAN FAX]

Patient	[PATIENT NAME], born [DATE OF BIRTH]
Member / beneficiary ID	[MEMBER ID]
Plan	[PLAN NAME] (Medicare Advantage)
Service appealed	neck fusion, back approach (CPT [CPT CODE])
Diagnosis	[DIAGNOSIS]
Denial reference	[DENIAL REFERENCE]
Date of denial	[NOTICE DATE]
Treating physician	[CLINICIAN NAME], [CREDENTIALS], NPI [NPI]

I am the patient's treating physician. I ask [PLAN NAME] (Medicare Advantage) to reconsider its denial, dated [NOTICE DATE], of neck fusion, back approach (CPT [CPT CODE]), before the care is given. A physician who is treating an enrollee may ask for a standard reconsideration of a pre-service request on the enrollee's behalf after giving the enrollee notice (42 CFR 422.578 and 422.582(a)).

Notice to the patient: I gave the patient notice of this request before sending it. How: [HOW NOTICE WAS GIVEN]. Date: [DATE OF NOTICE].

The reason the plan gave

Conservative care not shown (reason class). Notice wording: [practice adds from the notice].

Answer to the plan's reason

The plan said conservative care was not shown. The rows on care tried before this service point to the chart pages that record what was tried and why it was not enough or could not be tolerated. In the enclosed table: row 2 (exhibit C).

Medicare's coverage rule for this service

Novitas Solutions, Inc., the Medicare contractor for Texas, publishes local coverage determination L39793 (Cervical Fusion). A Medicare Advantage plan must follow the written coverage decisions of the local Medicare contractor (42 CFR 422.101(b)(3)). It may not deny basic benefits on coverage criteria that are not in those rules (42 CFR 422.101(c)(1)(i)(A)). It may use its own internal coverage criteria only when Medicare's criteria are not fully established, and then only if it makes them publicly accessible (42 CFR 422.101(b)(6)).

What the records show

- Arm pain rated 4 or more of 10 has lasted at least 12 weeks in this episode.
- Conservative care (medicine with therapy or a home exercise program) did not give enough relief.
- Nerve compression limits the patient's daily activities.
- MRI or CT shows narrowing at the level that matches the exam findings.

The criteria table lists each requirement of L39793 in short words, what the records show, and the page where it appears.

What I ask

- Reconsider the denial against L39793 and the enclosed records.
- State the specific reason for the denial (42 CFR 422.122(a)).
- If the plan used internal coverage criteria, name them and say where they are published, with the evidence summary and rationale that 42 CFR 422.101(b)(6)(ii) requires the plan to make public.
- Have a physician whose field of medicine fits this service make the reconsidered decision (42 CFR 422.590(h)(2)).

- Decide within the time in 42 CFR 422.590: no later than 30 calendar days after receipt for a standard request, or 72 hours for an expedited one. If the plan upholds any part of the denial, it must send the case file to the independent entity (42 CFR 422.590(a)(2)).

Contact: [PHONE], fax [FAX].

Sincerely, [CLINICIAN NAME], [CREDENTIALS], treating physician, [PRACTICE NAME]

Criteria table

The criteria below are our short wording of Medicare's local coverage determination L39793 (Cervical Fusion), published by Novitas Solutions, Inc., the Medicare contractor for Texas (public government text). A Medicare Advantage plan must follow it (42 CFR 422.101(b)(3)). The physician checks each row against the LCD itself.

#	Requirement (Medicare LCD L39793)	What the records show	Exhibit	Shown / Not shown
1	L39793: arm pain rated 4 or more of 10 for at least 12 weeks in this episode	Arm pain rated 4 or more of 10 has lasted at least 12 weeks in this episode.	A	Shown: found in chart, page ____
2	L39793: conservative care tried and failed, as tolerated, unless an exception applies	Conservative care (medicine with therapy or a home exercise program) did not give enough relief.	C	Shown: found in chart, page ____
3	L39793: nerve compression limits daily activities	Nerve compression limits the patient's daily activities.	A	Shown: found in chart, page ____
4	L39793: other sources of the pain or deficit ruled out	[physician to confirm]	D	Not shown. Physician to confirm
5	L39793: MRI or CT shows narrowing at the level that matches the exam	MRI or CT shows narrowing at the level that matches the exam findings.	B	Shown: found in chart, page ____
6	The treating physician gave the patient notice of this request (42 CFR 422.578)	Notice given: [HOW NOTICE WAS GIVEN]	F	Shown: found in chart, page ____
7	The plan's specific reason for the denial (42 CFR 422.122(a))	Asked for in this request	E	Asked of the plan
8	Any internal coverage criteria the plan used, and where they are published (42 CFR 422.101(b)(6))	Asked for in this request	E	Asked of the plan

Shown: the office ticked this box; write the chart page in its blank. Not shown: no box was ticked; the physician checks the chart, then ticks the box and rebuilds, or decides not to send. Asked of the plan: this request asks the plan for it.

Rule version used: the version of L39793 in force when this request is sent.

Exhibit list

Each exhibit is part of the practice's own chart. The practice pulls it, writes its pages in the blank, and puts it behind this list in letter order. This service holds none of these pages.

Exhibit	What to pull from the chart	Criteria rows	Pages
A	Visit notes with the history, the arm pain score and the nerve exam	1, 3	page ____
B	The MRI or CT report at the level to be treated	5	page ____
C	Conservative care records: therapy or home exercise notes and the medicine list	2	page ____
D	Notes or tests that rule out other sources of the pain or deficit	4 (not shown yet: 4)	page ____
E	The plan's denial notice, with its reference	7, 8	page ____
F	The practice's note of the notice given to the patient	6	page ____

A row marked Shown needs its page in the blank before the physician signs. If the chart has no page for an exhibit, write none in its blank; the rows it supports stay Not shown.

Deadline sheet

Which clock applies: Medicare Advantage reconsideration, standard. Each rule is in words, with a blank for the date.

What	When	Source
Plan's written denial	Notice date: _____	Plan notice
Notice counted as received	5 calendar days after the notice date, unless shown otherwise. Date: _____	42 CFR 422.582(b)(1)
Last day to file this request	60 calendar days after the notice is received. It counts as filed when the plan, or the office named on the notice, receives it. Last day: _____	42 CFR 422.582(b); 422.584(b)
Filed late	The plan may extend the window for good cause. The request must be in writing and say why it is late	42 CFR 422.582(c)
Request received by the plan	Date: _____	Practice
Standard decision due	As fast as the patient's health requires, and no later than 30 calendar days after receipt. Last day: _____	42 CFR 422.590(a)(1)
Expedited decision due	As fast as the patient's health requires, and no later than 72 hours after receipt. Last day and hour: _____	42 CFR 422.590(e)(1)
Extension	The plan may extend either deadline by up to 14 calendar days in the listed cases, and must tell the patient in writing why	42 CFR 422.590(f)
Expedited request turned down	The plan moves it to the standard 30-day clock, from the day it got the request, and tells the patient	42 CFR 422.584(d)
If the plan upholds any part of the denial	It sends the case file to the independent entity: standard, within the 30 days; expedited, within 24 hours of its decision	42 CFR 422.590(a)(2), (e)(5)
If the plan misses its deadline	That counts as upholding the denial, and the file goes to the independent entity	42 CFR 422.590(d), (g)

This packet holds no dates for the patient. Read the notice date off the plan's notice, count calendar days, and write each last day in its blank. These are federal Medicare Advantage rules: Texas chapter 4201 dates do not apply.

Peer-to-peer brief (one page)

Patient	[PATIENT NAME], member ID [MEMBER ID]
Request	neck fusion, back approach (CPT [CPT CODE])
Denial reference	[DENIAL REFERENCE]
Physician on the call	[CLINICIAN NAME], [CREDENTIALS]

Say first

I am the treating physician, and I asked the plan to reconsider its denial before care. Medicare's coverage rule L39793 sets the requirements for this service, and the plan must follow it. I would like to go through what the records show.

The plan's reason

The plan said: Conservative care not shown. The row that answer it: 2.

Points, strongest first

- Row 2. Conservative care (medicine with therapy or a home exercise program) did not give enough relief. (L39793: conservative care tried and failed, as tolerated, unless an exception applies; chart page ____)
- Row 1. Arm pain rated 4 or more of 10 has lasted at least 12 weeks in this episode. (L39793: arm pain rated 4 or more of 10 for at least 12 weeks in this episode; chart page ____)
- Row 3. Nerve compression limits the patient's daily activities. (L39793: nerve compression limits daily activities; chart page ____)
- Row 5. MRI or CT shows narrowing at the level that matches the exam findings. (L39793: MRI or CT shows narrowing at the level that matches the exam; chart page ____)

Ask the reviewer

- Which requirement, if any, do you see as not met?
- Which page of the record would show it to you?
- Did the plan use internal criteria? If so, which ones, and where are they published?
- Can the denial be reversed on this call, or after the missing page is sent?

Write down after the call

- Reviewer name and specialty
- Date and time of the call
- Any item the reviewer says is missing
- Next step and who owns it

Physician review and signature

Nothing in this packet is sent until the physician below has read it against the patient's records.

This request is made by the patient's treating physician (42 CFR 422.578). The physician below signs it.

Name	[CLINICIAN NAME]
Credentials	[CREDENTIALS]
NPI	[NPI]
Date	_____

Attestation: I have reviewed this packet against the patient's records. Each statement is supported by the records or is marked for my change. I approve it to be sent.

Signature: _____

Date: _____

This packet is not a substitute for the advice of an attorney.