**Sample Appeals Letter**

*The following template is a sample letter of appeal for an insurance claim denied on the basis of being “not medically necessary.” Given that the sample letter is generic, the dental professional is encouraged to personalize the letter and modify it to reflect specific issues pertinent to the insurer’s policies.*

Date:

Attention: *(Name of Contact Person at Insurance Company*)

(*Name of Insurance Company)*

*(Address of Insurance Company)*

*(City, State, Zip Code)*

Re:

(*Name of Patient*)

(*Address of Patient*)

 DOB: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

SSN: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Member No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group/ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_

Dear (*Insert Name of Contact Person at Insurance Company*):

On behalf of my patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*Insert Name of Patient*), I am appealing your decision to deny payment for oral appliance therapy based on your determination that the treatment is not medically necessary. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*Insert Name of Patient*) has been diagnosed with obstructive sleep apnea, for which he/she sought treatment for the condition at my office. The initial visit occurred on \_\_\_\_\_\_\_\_\_\_\_\_ (*Insert Date*).

Obstructive sleep apnea (ICD-9-CM: 327.23) is a MEDICAL condition. One of the treatment modalities approved for obstructive sleep apnea by both Medicare and the American Academy of Sleep Medicine is oral appliance therapy when implemented using a custom-fabricated and fitted mandibular advancement device or splint. In the case of my patient, a mandibular advancement device was provided. Thus, in this case the oral appliance therapy is a MEDICAL treatment for a MEDICAL condition; it is not a DENTAL treatment. The oral appliance therapy is indicated because my patient was not able to tolerate CPAP therapy.

According to both Medicare and the American Academy of Sleep Medicine, oral appliance therapy is indicated for first-line treatment of mild to moderate obstructive sleep apnea in patients who prefer oral appliance therapy to CPAP therapy and it is indicated for patients with severe forms of obstructive sleep apnea who cannot tolerate CPAP therapy or for whom CPAP therapy is contraindicated. Current evidence-based research demonstrates favorable outcomes with the use of mandibular advancement devices or splints.

In support of this claim, please find enclosed a copy of the polysomnography results confirming the diagnosis of obstructive sleep apnea and letter of medical necessity and prescription for oral appliance therapy from my patient’s physician. Also I am including a copy of the patient’s affidavit certifying that he/she cannot tolerate CPAP therapy along with a copy of the AASM’s recommended guidelines for oral appliance therapy as presented in its positional paper, *Practice Parameters for the Treatment of Snoring and Obstructive Sleep Apnea with Oral* *Appliances: An Update for 2005” in the February 2006 edition of Sleep [2006;29(2): 240-243].*

Additionally, my clinical findings and observations are as follows:

Past Medical History:

Hypertension

GERD

Depression

Family History:

Hypertension

Type II Diabetes

Depression

Obstructive Sleep Apnea Syndrome: Father and Brother

Past Dental History:

Patient does not have significant history of dental disease

Patient denies any temporomandibular joint pain.

Physical Examination:

Periodontium: No evidence of significant periodontal disease; periodontal pockets are < 4 mm

Teeth: Adequate dentition for oral appliance

Numerous restorations on teeth but restorations appear to be in good condition

Occlusion: Normal Angle Class I

Range of mandibular motion: Normal

Maximum opening = 43mm

Right and left maximum lateral movement of the jaw = 9mm

Maximum protrusive movement = 11mm

No deviation or deflection of the mandible upon opening

Intercanine maxillary arch width = 35mm

Intercanine mandibular arch width = 30mm

Oropharynx: Relatively normal with the exception of a swollen and enlarged uvula

Tonsillar Hypertrophy Grading Scale: Grade I

Mallampati Score: Grade III

Soft palate: Very long and appears to obstruct airway

Hard palate: Moderately vaulted

In my opinion, denial of this claim was not justified on the basis of not being medically necessary. The explanation of benefits did not give adequate information to establish the validity of your decision. Therefore, please provide the following information to support your denial of the claim: 1) Name and credentials of the insurance representative who reviewed the treatment records along with an outline of the specific records reviewed; 2) Copies of any expert medical opinions that may have been used in deliberating on the medical necessity of treatment of this nature so that the treating physician may respond to its applicability to my patient’s condition.

In light of the possibility that denial of this claim may jeopardize my patient’s access to appropriate health care, I am requesting that you reevaluate this claim and reconsider your decision to deny payment. If further documentation or medical records are needed, please advise me accordingly. I can be reached at the following telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Thank you for your prompt attention to this matter.

Sincerely,

(Dentist’s Signature)