**Spinal Cord Stimulation Appeal Template**

**(INSERT PHYSICIAN LETTERHEAD)**

Insurance Company Name

Attn: Appeals Department

Street Address

City, State, Zip

Patient Name:

ID Number:

Group Number:

Date of Birth:

Procedure Codes: Specify Trial or Implant Code(s)

63650 Percutaneous implantation of neurostimulator array, epidural

63685 Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling

Principle Diagnosis: (Insert DX here)

To Whom It May Concern:

This letter is in response to your recent denial of coverage for spinal cord stimulation (SCS) therapy for my patient (Patient Name) and is a request for reconsideration for the implantation of a spinal cord stimulator. Attached is a copy of your denial notice, dated (insert date of denial letter), where you stipulate that the request does not meet medical necessity criteria.

Rationale for non-coverage communicated by the health plan states (insert non-coverage rationale). The health plan’s coverage policy (insert policy number and link) requires (insert summary criteria). It is my professional medical opinion that SCS is the best treatment option for my patient to treat (FBSS, CRPS etc.) who has been unresponsive to conservative care.

(Summary restatement of the H&P, dose/duration of therapeutics, dose/duration of epis, why patient may be less responsive or contraindicated for specific options. Include date and disposition of the psychological evaluation; and surgical clearance).

The patient meets coverage criteria of the health plan. It is my clinical determination (he/she) requires implantation of a spinal cord stimulator to address chronic pain symptoms, having tried and failed conservative interventions denoted above.

I am requesting immediate approval for SCS therapy for your beneficiary, (Patient Name) and appreciate your expedited response for coverage.

Please contact me directly if you require additional information or if you would like to discuss the specifics of this case. I can be reached at PHONE # or by email at EMAIL ADDRESS.

Thank you in advance for your consideration of this request.

Sincerely,

Physician Name

Facility Name

Full Address

Phone

Attachments: (copy of H&P, copy of psychological evaluation)

<https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=240>

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