Date

Maximus Pre-Service Appeals Department   
[Address]  
[City, State and ZIP Code]

Re: [Patient's Name]  
Medicare Number: [Medicare Number]

Reference Number: [from denial letter]

**Subject: 2nd Level IRE Appeal of Denial of Coverage for** [Type of Hematopoietic Stem Cell Transplant]

Dear Appeal Reviewer:

I am requesting a 2nd level “IRE” appeal on behalf of my *Medicare Advantage* patient, [Patient's Name], for the following adverse decision made by [name of Medicare Advantage insurer], which is included as an attachment to this memorandum [include copy of the plan’s initial denial letter]. The request is for coverage for [enter ICD-10-PCS procedure code and short description here] for [enter ICD-10-CM diagnosis code and short description here].

The first appeal/reconsideration was denied for the stated reason [put the reason here] by [insert name of reviewer if on denial letter]. Please understand that the reason given for denial is not valid [put reason here].This combination of diagnosis and procedure code are covered by Medicare according to [NCD 110.8.1 – Stem Cell Transplantation](http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=45&ncdver=5&NCAId=9&IsPopup=y&bc=AAAAAAAAAgAAAA==&). HCT is a standard treatment for this condition and is NOT being provided through a clinical trial, so no clinical trial number is included OR the [NCD 110.8.1 – Stem Cell Transplantation](http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=45&ncdver=5&NCAId=9&IsPopup=y&bc=AAAAAAAAAgAAAA==&) does not specify coverage or non-coverage for the requested codes, however HCT is a standard treatment for this condition and I am submitting additional information which will help you understand why this is the [best? only?] appropriate treatment for this patient.

[Indicate here if patient has had and failed prior treatment – describe what the treatment was and the current state of the patient’s disease.]

**OR**

[Indicate here what alternative treatments are and why they are not appropriate for this patient.]

HCT[ [offers patients with this condition only chance of cure?] **OR** [Is the standard of care for this condition – explain in detail why transplant is the best treatment choice]. With transplant the likely outcome for [patient name] is [insert likely outcomes and longevity – insert any data you have here].

Transplant for [X condition] is accepted as the standard of care, and is well supported by respected scientific literature. [Summarize literature findings here.]

Please review the following enclosed medical journal articles that support this position:

* **Article #1**
* **Article #2**
* **Article #3**

**OR**

Due to the small number of patients with this [deadly? rare?] disease, it is not possible to obtain enough participants for a clinical trial, hence we must rely on small case series to guide treatment. [Summarize published findings.] [Explain why you are taking the approach you are.]

* **Article #1**
* **Article #2**
* **Article #3**

Based on the available medical literature on [Patient's Name’s] condition, I am filing this appeal, specifically requesting that you approve the required [transplant type] that was denied. Transplant is the [only available **OR** best] treatment option for this condition and for this patient. Not approving this transplant leaves this patient with [insert prognosis here].

Sincerely,

[Physician's Name]**, M.D.**

**Enclosures:**

1. Copy of the Medicare Advantage plan denial letter
2. Documents referred to in text
3. Signed Authorization of Representative Form