[Your Name/Organization Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Payer Name]
[Attn: Appeals Department]
[Address]
[City, State, Zip Code]

RE: Appeal of Level of Service Downgrade

Patient Name: [Patient Name]
Policy Number: [Policy Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Original CPT Code: [Original Code, e.g., 99214]
Downcoded CPT Code: [Downcoded Code, e.g., 99213]

Dear Appeals Committee,

This letter serves as a formal appeal to your decision to downgrade the Evaluation and Management (E/M) level for the above-referenced claim. The service was originally billed as [Original Code], but was processed and reimbursed at the lower level of [Downcoded Code].

We have reviewed the clinical documentation for this encounter and maintain that the original code submitted accurately reflects the complexity of the medical decision-making (MDM) and/or the total time spent on the date of the encounter, in accordance with the CPT Evaluation and Management Services Guidelines.

Specifically, the level of service is justified based on the following criteria:

- **Number and Complexity of Problems Addressed:** [Describe complexity, e.g., Multiple chronic illnesses with exacerbation]
- **Amount and/or Complexity of Data Reviewed:** [Describe data, e.g., Review of external records, independent interpretation of tests]
- **Risk of Complications/Morbidity:** [Describe risk, e.g., Prescription drug management, high-risk surgery decision]

Enclosed you will find the complete medical record for this date of service to support our position. We request that you re-evaluate this claim and provide the additional reimbursement due for the level of service provided.

Thank you for your prompt attention to this matter. Please contact [Contact Name] at [Phone Number] if you require further information.

Sincerely,

[Signature]
[Printed Name and Title]

Enclosures: Copy of Medical Records, Original Claim Form, Remittance Advice