

[Your Clinic Name]  
[Billing Department Address]  
[City, State, Zip Code]  
[Phone Number]  
[Tax ID/NPI Number]

[Date]

[Insurance Company Name]  
[Appeals Department Address]  
[City, State, Zip Code]

**RE: Appeal for Incorrect Downcoding**

**Patient Name:** [Patient First and Last Name]  
**Date of Birth:** [MM/DD/YYYY]  
**Policy/Member ID:** [ID Number]  
**Claim Number:** [Claim Number]  
**Date of Service:** [Date of Visit]  
**Original CPT Code Submitted:** [e.g., 99284 or 99285]  
**Downcoded CPT Code:** [e.g., 99282 or 99283]

To Whom It May Concern,

This letter is a formal appeal regarding the reimbursement for the above-referenced claim. Our records indicate that the level of service submitted was downcoded by your organization, resulting in a reduction of payment.

The medical documentation attached demonstrates that the complexity of the patient's presenting symptoms and the medical decision-making (MDM) required at the time of the encounter accurately reflect the original CPT code submitted. Based on the 2023 CPT Evaluation and Management (E/M) guidelines, the level of service is determined by the complexity of the problems addressed, data reviewed, and the risk of complications or morbidity.

Specifically, this encounter required:

- [Mention complexity of presenting problem, e.g., acute illness with systemic symptoms]
- [Mention amount/complexity of data reviewed, e.g., multiple tests ordered, independent history]
- [Mention risk of management, e.g., prescription drug management or emergency surgery decision]

Downcoding this claim based on a retrospective review of the final diagnosis, rather than the "Prudent Layperson Standard" and the resources required at the time of presentation, is inconsistent with standard billing practices. We request that you re-evaluate the attached medical records and adjust the claim to the original level of service submitted.

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

Sincerely,

[Your Name/Signature]

[Your Title]

[Clinic Name]

**Enclosures:**

- Original Claim Form
- Clinical Documentation/Physician Notes
- Explanation of Benefits (EOB)