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

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

RE: Appeal for Denied Claim (Mutually Exclusive Codes)
Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy ID: [Policy ID]
Claim Number: [Claim Number]
Date of Service: [Date of Service]

To Whom It May Concern:

This letter serves as a formal appeal regarding the denial of the following codes: [Denied Code 1] and [Denied Code 2]. The denial was based on the rationale that these codes are "mutually exclusive" according to NCCI edits. We are requesting a reconsideration based on the specific clinical necessity and distinct nature of the procedures performed during this encounter.

Clinical Justification:

The procedures performed were not redundant, nor was one a component of the other. Clinical documentation supports that:

- [Reason 1: e.g., Procedures were performed at different anatomical sites.]
- [Reason 2: e.g., Procedures were performed through separate incisions/access points.]
- [Reason 3: e.g., The second procedure was medically necessary due to an unrelated clinical finding discovered during the first procedure.]

As per the attached operative report, [Modifier -59 or relevant modifier] was utilized to indicate that these procedures were distinct and independent. The clinical complexity of this case required both services to be performed to ensure the standard of care for the patient.

Attached Documentation:

- Original Claim Form
- Operative/Procedure Report (Highlighted sections)
- Clinical Progress Notes
- [Any other relevant medical records]

We kindly request that you review the attached documentation and process the claim for full payment. If you require further information, please contact [Contact Person Name] at [Phone Number].

Sincerely,

[Signature]
[Printed Name]
[Title/Credentials]