

## Sample Letter of Appeal

**Physician's name and address**

**Date**

**Address of Claims review department**

**[Attn: Claims Department]**

**Re: [Patient Name]**

**[Policy Number, Group Number, Patient ID Number]**

**Treatment Date and Claim Number**

**Amount [provide total dollar amount of charges filed]**

To Whom It May Concern:

This letter of appeal is submitted in response to the **<date of denial letter>** denial of coverage authorization letter received for Ms. **<Patient's Name>** reduction mammoplasty.

Patients with symptomatic breast hypertrophy suffer from severe symptoms directly related to the weight of their excess breast volume. The justification for reduction mammoplasty should be based on the probability of relieving the clinical signs and symptoms of symptomatic breast hypertrophy. Scientific literature, published in peer reviewed journals, indicates that women undergoing reduction mammoplasty for symptomatic breast hypertrophy experience significant improvement in their preoperative symptoms and quality of life.<sup>1, 2, 3</sup>

Resection weight thresholds are often used as a determinant for insurance coverage criteria. While a few studies have attempted to validate the relationship between resection weight and medical necessity, currently no study exists that provides a sound scientific rationale for this theory. The commonly used Schnur Sliding Scale suggests that resection weights above the 22<sup>nd</sup> percentile should be regarded as reconstructive, while resection weights falling below the 5<sup>th</sup> percentile should be deemed cosmetic.<sup>4</sup> However, from a scientific standpoint, the basis for developing this scale is flawed. The Schnur scale recommendations are derived from a survey that asked plastic surgeons their perceptions of their patients' motivations for reduction mammoplasty (i.e. reconstructive or cosmetic).<sup>4</sup> This survey study design, based on surveyed perception of others, is susceptible to significant bias and does not meet ASPS' inclusion criteria for being a moderate or high quality study. Schnur himself has even challenged insurance carriers' misuse of the scale and has indicated that the scale should no longer be used as criteria for insurance coverage.<sup>5</sup>

The criteria for reduction mammoplasty are more accurately defined by individual symptomatology rather than breast resection weight alone. Evidence indicates that women, across a wide range of breast sizes, experience similar benefits from reduction mamamplasty. According to two prospective studies, women of varying breast sizes, experience similar preoperative symptoms and similar postoperative relief and quality of life improvement regardless of the total resection volume.<sup>6,7</sup>

In addition, conservative measures have been found to be ineffective in permanently relieving symptoms related to breast hypertrophy. According to the findings of a Level II, prospective study, non-surgical therapies, such as support bras, physical therapy, exercise, and medications, have been found to be ineffective in providing permanent relief of breast hypertrophy symptoms.<sup>8</sup> To date, there are no studies published affirming the cost effectiveness of conservative measures as a first line therapy for the treatment of symptomatic breast hypertrophy.

As documented in the office notes of **<date>**, Ms. **<Patient's Name>** suffers from symptomatic breast hypertrophy. Reduction mammoplasty is a medically necessary procedure when performed for the relief of symptomatic breast hypertrophy. As a physician, I have a duty to advocate for medically necessary care that will benefit my patient. Therefore, I request to re-review this case.

I am copying <Patient's Name> on this appeal letter and will include this letter as part of her medical record. Thank you for your consideration, I await your prompt response.

Sincerely,

Physician's Name

cc: Patient's Name

References:

1. Saariniemi, K. M., Keranen, U. H., Salminen-Peltola, P. K., Kuokkanen, H. O. Reduction mammoplasty is effective treatment according to two quality of life instruments. A prospective randomised clinical trial. *J Plast Reconstr. Aesthet. Surg* 61: 1472-1478, 2008.
2. Freire, M., Neto, M. S., Garcia, E. B., Quaresma, M. R., Ferreira, L. M. Functional capacity and postural pain outcomes after reduction mammoplasty. *Plast Reconstr. Surg* 119: 1149-1156, 2007.
3. Iwuagwu, O. C., Walker, L. G., Stanley, P. W., Hart, N. B., Platt, A. J., Drew, P. J. Randomized clinical trial examining psychosocial and quality of life benefits of bilateral breast reduction surgery. *Br. J Surg* 93: 291-294, 2006.
4. Schnur, P. L., Hoehn, J. G., Ilstrup, D. M., Cahoy, M. J., Chu, C. P. Reduction mammoplasty: cosmetic or reconstructive procedure? *Ann. Plast Surg* 27: 232-237, 1991.
5. Schnur, P. L. Reduction mammoplasty-the schnur sliding scale revisited. *Ann. Plast Surg* 42: 107-108, 1999.
6. Kerrigan, C. L., Collins, E. D., Kim, H. M. et al. Reduction mammoplasty: defining medical necessity. *Med Decis. Making* 22: 208-217, 2002.
7. Spector, J. A., Singh, S. P., Karp, N. S. Outcomes after breast reduction: does size really matter? *Ann. Plast Surg* 60: 505-509, 2008.
8. Collins, E. D., Kerrigan, C. L., Kim, M. et al. The effectiveness of surgical and nonsurgical interventions in relieving the symptoms of macromastia. *Plast Reconstr. Surg* 109: 1556-1566, 2002.