

Sample Letter of Request for Appeal – Claim Denial

[Date]

[Health Plan Name]
[Street Address]
[City, State Zip]

RE: [Patient's Name/Policy Number]
Claim Number: [claim #]

To Whom It May Concern:

I am writing to appeal the enclosed claim denial of coverage for the insertion of The Spanner™ prostatic stent for my patient, [patient's name] that was performed on [date of service]. The decision to perform this service was based on my extensive medical knowledge and first-hand evaluation. This letter provides the rationale for using this treatment, a description of the procedure, and a summary of the clinical results associated with The Spanner prostatic stent.

Clinical Rationale for Treatment with The Spanner

My patient's condition and medical history in this case warrant treatment with a prostatic stent. [Patient's name]'s condition, [note diagnosis, whether confirmed or not], profoundly impacts [his] [lifestyle, ability to work, etc.]. [Note whether this patient had undergone previous treatments and what treatment options were likely to be recommended next. Include all relevant medical records/documentation.]

Treatment of Bladder Outlet Obstruction Using The Spanner Prostatic Stent

The Spanner Prostatic Stent is the technology I use to maintain urine flow and allow voluntary urination. The Spanner was originally cleared for commercial distribution by the U.S. Food and Drug Administration on December 14, 2006.

The Spanner Prostatic Stent is a steel wire reinforced silicone stent, which may be used to improve urine flow and maintain voluntary urination. The Surveyor is first used to measure the length of the urethra from the bladder neck to the distal side of the sphincter. Insertion is accomplished with the stent mounted on an Introducer that is passed into the bladder. The distal balloon is then inflated using sterile water and the Introducer withdrawn until the balloon abuts the bladder neck. The stent is the only component which remains in situ. The stent lies between the bladder neck and external sphincter held in position by the inflatable balloon; a suture crosses the external-sphincter allowing the patient to remain continent. The retrieval tether is trimmed such that the distal end is just inside the meatus or may be left extending

beyond the meatus.

Indications for Use

The Spanner is intended for temporary use (up to 30 days) to maintain urine flow and allow voluntary urination in patients following minimally invasive treatment for benign prostatic hyperplasia (BPH) and after initial post-catheterization.

Clinical Evaluation of The Spanner

The Spanner randomized controlled trial evaluated the safety, efficacy and patient tolerance of The Spanner in men during their post- microwave thermotherapy (TUMT) healing period. The outcomes of 100 men in the Spanner group were compared to those of 86 men in the Standard of Care control group.

Spanner men had significantly greater improvements in BPH symptoms as measured by the International Prostate Symptom Score ($p=0.019$), and in the uroflowmetry parameters such as peak flow rate ($p<0.05$) and post void residual ($p =0.001$) compared to the control group. As assessed just prior to removal, patient satisfaction with the stent exceeded 86%. Also, 85% of subjects indicated that they would recommend Spanner use to a friend.

Eighty-two percent of the Spanner patients reported “no” or “mild” discomfort during insertion. During removal 82% of subjects reported “no” or “mild” discomfort.

Cystoscopic assessment of the two groups was comparable suggesting that the urethra and bladder were in similar condition post-TUMT regardless of the presence of the Spanner. Finally there was no statistical difference between the Spanner and the Standard of Care control group for the rates of adverse events requiring treatment.

Request for Coverage

In my practice, patients treated with The Spanner are demonstrating [\[excellent clinical response\]](#) to this treatment. My personal experience mirrors results described in the clinical trial. It is my clinical opinion that my patient; [\[Patient name\]](#)'s condition and medical history in particular make him a viable candidate for treatment with The Spanner. The procedure is clearly medically necessary for his condition at this time and warrants coverage. I therefore request that you re-review this claim and provide a favorable coverage decision.

If you require additional information, please contact me at [\[insert telephone number\]](#).

Sincerely,

[\(Physician Name\)](#)
[\(Provider number\)](#)
[\(Street Address\)](#)
[\(City, State Zip\)](#)