**The health care provider (“HCP”) is responsible for determining the medical necessity of a product for the HCP’s patient. This example letter does not provide medical or legal advice about what is or may be medically necessary. This is merely an example letter that sets forth a sample format for establishing the medical necessity of an implantable hearing solution for a patient. This example may not be applicable to all situations and is no guarantee of coverage.**

**\*\*DELETE ALL BLUE TEXT PRIOR TO SUBMITTING THE DOCUMENT\*\***

Date

Health plan name

Attn: Appeal department

Address

#

Re: Patient:

 ID#:

 DOB#:

**Appeal for Denial of Benefit for a Cochlear Implant for SSD**

Dear Appeals Reviewer:

I am writing to appeal the recent denial of benefits for the Cochlear™ Nucleus® Implant System. The denial letter dated **(date)** states the denial reason as **[Insert denial reason here]**.

Cochlear Nucleus Implant System is (**not experimental or investigational/medically necessary)**. On January 10, 2022 the FDA approved (P970051/S205) the expanded indications for theCochlear Nucleus Implant System. The expanded device indications include individuals with unilateral hearing loss who meet the following criteria:

* Individuals 5 years or older who have one ear with a severe to profound sensorineural hearing loss and obtain limited benefit from an appropriately fitted unilateral hearing device and one ear with normal or near normal hearing.
	+ - In the ear to be implanted, a severe to profound sensorineural hearing loss is defined as a PTA at 500 Hz, 1000 Hz, 2000 Hz and 4000 Hz of > 80 dB HL.
		- In the contralateral ear, normal or near normal hearing is defined as a PTA at 500 Hz, 1000 Hz, 2000Hz and 4000 Hz ≤ 30 dB HL.
* Limited benefit from an appropriately fit unilateral hearing device is defined as a score of less than or equal to 5% on a Consonant Nucleus Consonant (CNC) word test. For individuals between 5 years and 18 years of age, insufficient functional access to sound in the ear to be implanted must be determined by aided speech perception test scores of 5% or less on developmentally appropriate monosyllabic word lists when tested in the ear to be implanted alone.
* (patient name) has completed a trial of at least 2 weeks wearing appropriately fit Contralateral Routing of Signal (CROS) hearing aid or another suitable hearing device.

**(patient name)** suffers major issues (select appropriate for specific patient) that can be greatly helped with the restoration of hearing via a cochlear implant, which replaces the functioning of a nonfunctioning body organ/part:

1. difficulty localizing sounds

2. poor hearing in background noise, difficulty understanding conversations in noisy environments

3. inability to hear well a person talking on the “bad” side

There are significant safety concerns when one cannot localize where sound is coming from, and one-sided hearing is making it difficult for **(patient name)** to understand speech and to communicate well in his/her daily listening environment. <insert specific examples that describe the specific individual’s hearing and communication difficulties examples might be: ---- has a number of near misses with motor vehicles or almost hit by car when crossing a busy street. ----- is suffering in her/his workplace because of not being able to hear. ----- misses most conversations at work/school/… because people will talk softly on the nonhearing side or there is too much background noise>. This is causing poor performance reports and impacting **(patient name)** ‘s quality of life. Recently published studies have shown that patients who received a cochlear implant to treat **his/her UHL/SSD** demonstrated improved speech understanding in noise, improved sound localization and enhanced quality of life, (Arndt et al., 2017; Dorbeau et al., 2018; Häußler et al., 2020; Lorens et al., 2019: Peter et al., 2019)

It is the replacement of a non-functioning body part by a cochlear implant that is critical to restoring a level of function that would be of great benefit to **(patient name)** ‘s hearing complaint(s). Your policy covers the replacement of organs/body parts that are not functioning. Consider if the patient had a cataract only in one eye that affected sight; that cataract would be removed. It would not be denied because one could see out of the other eye normally or with corrective lenses. The same holds true in this situation. The effects of only hearing in one ear is devastating. **(patient name)** meets all criteria for cochlear implantation in the ear to be implanted as demonstrated by the testing enclosed.

We are thus respectfully asking you to reconsider your denial for (**patient name)** ‘s cochlear implant so - **(patient name)** can once again hear. I kindly ask that you please review the enclosed medical documents and reconsider your denial of benefits to cover (**patient name)** for the device and surgical implantation of the Cochlear Nucleus System. Please feel free to contact me at [insert phone/email address] if you have questions or need additional information.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name Print Physician Signature

Physician NPI#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician TAX ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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