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***Physician Note****: This sample letter template provides suggestions to assist in writing a Letter of Medical Necessity or prior authorization request for endovascular revascularization procedures (e.g., stents) for treating lower extremity ischemia. It is always the provider’s responsibility to determine the medical necessity of a service for a patient. This sample letter is not meant to be used as a form letter. Physicians should customize the letter based on the patient’s actual medical history, diagnosis and consistent with any specific United Healthcare requirements. It is very important to ensure all information provided to United Healthcare is accurate and medical necessity of the procedure is reflected in the patient’s medical record.*

**Sample Letter of Medical Necessity**

**Endovascular Revascularization for Lower Extremity Ischemia**

**Instructions for completing the letter of medical necessity:**

1. Please customize the letter based on the medical appropriateness of endovascular revascularization for treating lower extremity ischemia for your patient. Fields required for customization are highlighted in yellow.
2. It is important to provide the most complete information to assist with the prior authorization process.
3. After you have customized the medical necessity letter, please make sure to delete any specific instructions that are highlighted throughout the letter, so the health plan does not misinterpret the information.
4. Relevant CPT‡ codes, CPT‡ code descriptions, and other definitions are found in Appendix Table 1 and Table 2.

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[Date]

[Payer contact name]

[Payer contact title]

[Payer]

[Street address]

[City, State, zip code]

**Re: Request for Prior Authorization of Medical Services for Treatment of Lower Extremity Ischemia**

Patient name: [First and last name]

Patient date of birth: [XX/XX/XXXX]

SS # [XXX-XX-XXXX]

Insurance ID # [XXXXXXXXXXXXXXX]

Group # [XXXXXXXXXX]

Planned Date of Service: [XX/XX/XXXX]

Dear [Payer contact name]:

I am writing on behalf of my patient, [patient’s name], requesting prior authorization of coverage for [insert endovascular revascularization procedure (e.g., stents, angioplasty and/or atherectomy) and relevant CPT code(s) (See Appendix, Table 1)] for lower extremity ischemia, in an [inpatient/outpatient] setting at [facility name] scheduled on [planned procedure date].

**Background**

Peripheral artery disease (PAD) is a narrowing of vessels most commonly due to atherosclerotic plaques that cause arterial stenosis or occlusion, which decreases perfusion to extremities causing a potential threat to limb viability. Most patients are asymptomatic but may experience intermittent claudication or pain on walking. Chronic limb-threatening ischemia (CLTI) represents the end-stage of PAD. It occurs when the reduction in blood flow is so severe that it causes pain on rest or tissue loss.

Treatment options for PAD include lifestyle changes, medication management, endovascular revascularization techniques, and surgery. Endovascular revascularization techniques are reasonable treatment options for patients with lifestyle-limiting claudication and chronic limb-threatening ischemia (CLTI). Depending on the patient’s medical history, their symptoms, the underlying limb ischemia cause, and lesion characteristics, the most appropriate endovascular intervention is essential to the final limb outcome.

**Pertinent Clinical History**

My patient is a [insert age] year old [insert gender] who has [insert detailed diagnostic description and ICD-10 diagnosis codes]. [Insert a brief summary of the patients clinical information here, including A) relevant history and physical to include patient’s symptoms and pertinent findings due to ischemia, B) treatments tried, failed and/ or contraindicated, including structured exercise program, pharmacologic therapy, and smoking cessation, if applicable, C) details of functional disability(ies) interfering with activities of daily living, D) Ankle-Brachial Index score, and E) diagnostic imaging results documenting the location and severity of occlusion.]

**Treatment Rationale**

My patient is an appropriate candidate for [insert endovascular revascularization procedure (e.g., stents, angioplasty and/or atherectomy) and relevant CPT code(s) (See Appendix, Table 1)] for treating lower extremity ischemia based on the following indication-specific criteria provided by your health plan. Please complete below as relevant.

Claudication due to atherosclerotic disease of the aortoiliac and/or femoropopliteal arteries with **all** the following:

* Impaired ability to work and/or perform activities of daily living (ADL)
* All of the following conservative therapies have been tried and failed:
  + At least twelve (12) weeks of a [Supervised/Structured] Exercise Program
  + Pharmacologic therapy
  + Smoking cessation, if applicable
* Moderate to severe ischemic peripheral artery disease with ankle-brachial index (ABI) ≤ 0.69
* Imaging results show anatomic location and severity of occlusion (stenosis ≥ 50%) (e.g., duplex ultrasound, computed tomography angiography [CTA], magnetic resonance angiography [MRA] or invasive angiography)

CLTI with **all** the following:

* One or more of the following:

Pain at rest

Nonhealing wound or ulcer due to ischemia

Gangrene

* Moderate to severe ischemic peripheral artery disease with ABI ≤ 0.69
* Imaging results show anatomic location and severity of occlusion (stenosis ≥ 50%) (e.g., duplex ultrasound, CTA, MRA or invasive angiography)

I have discussed the procedure with my patient, and we are aligned in the recommendation of endovascular revascularization for [his/her] lower extremity ischemia with the goal to reduce symptoms and improve the ability to work and perform activities of daily living.

I feel that [patient name] will benefit significantly from this procedure. [Her/His] quality of life and well-being is greatly impacted by lower extremity ischemia.

I have attached relevant excerpts from the patient’s medical record, including relevant history and physical to include member symptoms and pertinent findings, signs and symptoms, treatments tried and failed, and results of diagnostic testing. I believe that endovascular revascularization for lower extremity ischemia is medically reasonable and necessary and warrants prior authorization of coverage and payment for this service.

Please let me know if I can provide any additional information. Thank you for your attention.

Sincerely,

[Physician’s name and credentials]

[Title]

[Name of practice]

[Street address]

[City, State, zip code]

[Phone number]

**Enclosures:**

[Patient medical records/chart notes documenting all of the following required clinical information:

1. Diagnosis
2. Relevant history and physical to include patient’s symptoms and pertinent findings due to ischemia
3. Treatments tried, failed and/ or contraindicated, including structured exercise program, pharmacologic therapy, and smoking cessation, if applicable
4. Details of functional disability(ies) interfering with activities of daily living
5. ABI score
6. Diagnostic images (e.g., duplex ultrasound, computed tomography angiography, magnetic resonance angiography, or invasive angiography) documenting the location and severity of occlusion]

\*\*Please delete the Appendix section, so the health plan does not misinterpret the information.

**Appendix**

**Table 1: Applicable CPT Codes & Description**

|  |  |
| --- | --- |
| **CPT‡ Code** | **Description** |
| 37220 | Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty |
| 37221 | Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed |
| 37224 | Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty |
| 37225 | Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed |
| 37226 | Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed |
| 37227 | Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed. |
| 37228 | Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty |
| 37229 | Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed. |

**Table 2. United Healthcare Definitions**

|  |  |
| --- | --- |
| **Term** | **Definition** |
| Ankle-Brachial Index (ABI) | The ABI compares blood pressure in the ankle to blood pressure in the arm and indicates how well blood is flowing in the limbs. Studies have shown that ABI can differentiate between normal and diseased limbs with a sensitivity of 97% and a specificity of 100% and that the resting ABI is a significant predictor of disease severity.  An ABI less than 9.0 indicates peripheral artery disease (PAD).   * Mild: 0.70 - 0.89 * Moderate: 0.40 – 0.69 * Severe: less than 0.40 |
| Chronic Limb-Threatening Ischemia (CLTI) | A condition characterized by chronic (≥ 2 weeks) ischemic rest pain, nonhealing wound/ulcers or gangrene in one or both legs attributable to arterial occlusive disease. Also referred to as critical limb ischemia (CLI) |
| Claudication | Fatigue, discomfort, cramping or pain of vascular origin in the muscles of the lower extremities that is consistently induced by exercise and consistently relieved by rest (within 10 minutes) |
| Structured Exercise Program | Components of a structured exercise program include all the following:   * Program takes place in the personal setting of the patient rather than in a clinical setting * Program is self-directed with guidance of healthcare provider(s) * Healthcare provides prescribe an exercise regimen similar to that of a Supervised Program. * Patient counseling ensures understanding of how to begin and maintain the program and how to progress the difficulty of the walking (by increasing distance or speed). * Program may incorporate behavioral change techniques, such as health coaching or use of activity monitors. |
| Supervised Exercise Program | Components of a Supervised Exercise Program include all the following:   * Program takes place in a hospital or outpatient facility * Program uses intermittent walking exercise as the treatment modality * Program can be standalone or within a cardiac rehabilitation program * Program is directly supervised by [qualified] healthcare provider(s) * Training is performed for a minimum of 30-45 minutes per session and sessions are performed at least 3 times per week for a minimum of 12 weeks. * Training involves intermittent bouts of walking to moderate-to-maximum claudication, alternating with periods of rest. * Warm-up and cool-down periods precede the following each session of walking. |

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