**SAMPLE LETTER OF MEDICAL NECESSITY TEMPLATE**

To be considered for prior authorization by physicians

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

1. Please customize the medical necessity letter template based on the medical appropriateness. Text requiring customization is in **RED**.
2. Letters of medical necessity are often key to requesting prior authorization of procedures.
3. After you have customized the letter, ***please make sure to delete this page and any specific instructions*** for completion, disclaimers, Abbott logos, caution statement, trademarks and document number that are seen throughout the letter so the health plan does not misinterpret the information.
4. For independent consideration and review, please make all changes that you believe appropriate or disregard these suggestions in their entirety. The customer is ultimately responsible for the accuracy and completeness of all claims submitted to third-party payers. Please see the FDA-approved label for information relevant to any prescribing decisions.

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*[Physician Letterhead]*

*[Date]*

Attention: Prior Authorization Department

*[Payer contact name]*

*[Payer contact title]*

*[Payer]*

*[Street address]*

*[City, State, zip code]*

**Re: Request for Prior Authorization of Left Atrial Appendage Closure (LAAC)**

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]*

**CPT‡ Code**: 33340, *Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation.*

I am writing on behalf of my patient, [patient’s name], requesting prior authorization for Left Atrial Appendage Closure (LAAC). This procedure is scheduled for an [inpatient/outpatient] setting at [facility name] on [planned procedure date].

**Treatment Rational**

I have examined this patient and conferred with my colleague, Dr. [insert name], who specializes in [insert specialty]. We have reached a shared decision with [Mr./Miss/MS/Mrs., insert patient name] that closure of the left atrial appendage with the Amplatzer™ Amulet™ Left Atrial Appendage Occluder device is medically necessary for this patient.

My patient also meets the CMS NCD[[1]](#endnote-2) criteria for coverage of LAAC as described below:

Per CMS NCD criteria, the patient must have:

* A CHADS2 score ≥ 2 (Congestive heart failure, Hypertension, Age > 75, Diabetes, Stroke/transient ischemia attack/thromboembolism) or CHA2DS2-VASC score ≥ 3 (Congestive heart failure, Hypertension, Age ≥ 65, Diabetes, Stroke/transient ischemia attack/thromboembolism, Vascular disease, Sex category.) My patient’s testing indicated a [insert patient CHADS2 orCHA2DS2-VASC score here]
* A formal shared decision making interaction with an independent non-interventional physician using an evidence-based decision tool on oral anticoagulation in patients with NVAF prior to LAAC. [insert patient information here or delete if non-applicable]
* A suitability for short-term warfarin but deemed unable to take long-term oral anticoagulation following the conclusion of shared decision making. The patient is under the care of a cohesive, multidisciplinary team (MDT) of medical professionals. [insert patient information here]

**Patient Clinical History**

*[Or Insert, if applicable]* Moreover, oral anticoagulation alone is not sufficient for this patient for the following reason(s): *[insert clinical reasons why this is a high risk of recurrent stroke and why this patient will benefit from LAA closure]. Consider including documentation of the following:*

* *Patients history of non-valvular AF*
* *Patient’s risk for stroke*
* *Concerns about long-term use of anticoagulation therapy such as*
	+ *Side effects: bleeding risk*
	+ *Low compliance*
	+ *Etc.*

**In closing**

I believe that closure of the left atrial appendage is medically reasonable and necessary and warrants prior authorization of coverage and payment for this service. 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.

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:

* ICD Diagnosis and indication for procedure
* Relevant history and physical to include member symptoms and pertinent findings due to atrial fibrillation
* Treatments tried, failed and/or contraindicated, including pharmacologic therapy, if applicable
* Documentation of patient suitability for anticoagulation
* CHADS2 or CHA2DS2-VASC score
* Diagnostic images (e.g., Transesophageal Echocardiography (TEE), intracardiac echocardiography (ICE), or computed tomography [CT]) documenting the suitability for an occlusion device
1. CMS National Coverage Determination (NCD) for Percutaneous Left Atrial Appendage Closure (LAAC) (20.34): https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=367 [↑](#endnote-ref-2)