

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. Fields required for customization are 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*** any specific instructions for completion, disclaimers, Abbott logos, caution statement, tradegraphs 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 Transcatheter Patent Foramen Ovale (PFO) closure

Patient name: [First and last name]

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

SS # [XXX-XX-XXXX]

Insurance ID # [XXXXXXXXXXXXXXX]

Group # [XXXXXXXXXX]

Date of Service: [XX/XX/XXXX]

CPT‡ Code:

[**93580** – Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant]

For physician and outpatient facility billing if billing Medicare or Medicare Advantage, the facility may also report:

[**C1817** – Septal defect implant system, intracardiac]

Inpatient for all payers:

[**02U53JZ** – Supplement atrial septum with synthetic substitute, percutaneous approach]

Dear [Payer contact name]:

I am writing to request prior authorization of services I deem medically necessary for the above-referenced procedure. The service involves the implant of the Amplatzer™ Talisman™ PFO Occluder to be provided to [patient’s name] on [procedure date] in the [inpatient/outpatient] setting at [facility name].

According to a comprehensive neurological assessment, [insert patients name] suffered from an ischemic stroke of undetermined etiology, – the so-called cryptogenic stroke. The diagnosis of cryptogenic ischemic stroke has been documented by the referring physician, and results of the following relevant tests are attached [Specify all tests that apply]

* Echocardiogram reports documenting diagnosis of Patent Foramen Ovale (PFO)
* Documentation of index cryptogenic ischemic stroke
* Test results for typical sources of cardioembolism as a cause for ischemic stroke
* ECG results for rhythm disorders such as Atrial Fibrillation or Flutter
* Echocardiogram reports for other cardiogenic sources of embolism
* Imaging of cerebral and extra-cerebral arteries for atherosclerotic causes of stroke
* Hematological evaluation for underlying hypercoagulable state
* [Additional examination and imaging as necessary]

The secondary stroke prevention for this patient includes [standard of care antithrombotic/specify] medical treatment. However, based on [patient name] medical history and my examination, in my professional opinion, I believe this patient could benefit from closure of their PFO for the following reasons: [insert benefits].

[Insert, if applicable] Moreover, this medical treatment cannot be [effective / tolerated/adhered to] by this patient for the following reason(s): [insert clinical reasons why the medical treatment alone is no longer sufficient or advisable for this patient]

[Or Insert, if applicable] Moreover, this medical treatment 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 PFO closure]

[And/Or Insert, if applicable, refer to Benefit Administrator’s medical policy] While [Insert Patient’s name] is currently over age 60, which is outside the predominant age range for PFO closure cited in your Medical policy, I strongly believe [he/she] will benefit from PFO closure for the following reasons: [Insert clinical reasons why this patients age is not a factor in treatment to reduce the risk of stroke]

I believe that in this case, PFO closure is medically reasonable and necessary and as such this service should receive prior authorization of coverage and payment for related services.

Please let me know if I can provide any additional information and 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]