**SAMPLE APPEAL LETTER FOR PRIOR AUTHORIZATION DENIAL TEMPLATE**

**Insertable Cardiac Monitor (ICM)**

**Instructions for completing the sample appeal letter:**

1. Please customize the appeal letter template based on the medical appropriateness. Text requiring customization is in **RED**.
2. After you have customized the letter, ***please make sure to delete this Instructions page and any RED text instructions***  that are seen throughout the letter.
3. For independent consideration and review, please make all changes that you believe appropriate or disregard these suggestions in their entirety. The healthcare provider 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.

**Disclaimer:**

This material and the information contained herein is for general information purposes only and is not intended, and does not constitute, legal, reimbursement, business, clinical, or other advice. Furthermore, it is not intended to and does not constitute a representation or guarantee of reimbursement, payment, or charge, or that reimbursement or other payment will be received. It is not intended to increase or maximize payment by any payer. Abbott makes no express or implied warranty or guarantee that the list of codes and narratives in this document is complete or error-free. Similarly, nothing in this document should be viewed as instructions for selecting any particular code, and Abbott does not advocate or warrant the appropriateness of the use of any particular code. The ultimate responsibility for coding and obtaining payment/reimbursement remains with the customer. This includes the responsibility for accuracy and veracity of all coding and claims submitted to third-party payers. In addition, the customer should note that laws, regulations, and coverage policies are complex and are updated frequently, and, therefore, the customer should check with its local carriers or intermediaries often and should consult with legal counsel or a financial, coding, or reimbursement specialist for any questions related to coding, billing, reimbursement, or any related issues. This material reproduces information for reference purposes only. It is not provided or authorized for marketing use.

**CAUTION:** Product(s) intended for use by or under the direction of a physician. Prior to use, reference the Instructions for Use, inside the product carton (when available) or at www.eifu.abbott for more detailed information on Indications, Contraindications, Warnings, Precautions and Adverse Events.

Information contained herein for DISTRIBUTION in the U.S. use ONLY.

**Abbott**

3200 Lakeside Dr., Santa Clara, CA 95054 USA Tel: 1.800.227.9902

One St. Jude Medical Dr., St. Paul, MN 55117, USA, Tel: 1 651 756 2000

www.cardiovascular.abbott

™ Indicates a trademark of the Abbott group of companies

‡ Indicates third party trademark, which is the property of its respective owner.

©2025 Abbott. All rights reserved. MAT-2507679 v1.0

*[Physician Letterhead] [Date]*

Attention: Appeals Department

Reference Number: *[ ] [Payer contact name]*

*[Payer contact title]*

*[Payer]*

*[Street address]*

*[City, State, zip code]*

**Re: Reconsideration of Prior Authorization Denial *(enter number)* for the subcutaneous cardiac rhythm monitor insertion, requesting review by a Same Specialty Provider**

Patient name: *[First and last name]*

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

Insurance ID # *[XXXXXXXXXXXXXXX]*

Group # *[XXXXXXXXXX]*

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

***Diagnosis:*** *(list ICD-10 Dx code and diagnosis code descriptor)*

***CPT Code****:* ***33285, Insertion, subcutaneous cardiac rhythm monitor, including programming***

Dear *[Payer contact name]*:

I am writing to request *reconsideration of the denial of prior authorization, [denial #],* for the above-referenced service. The service to be provided is a medically necessary implant of the insertable cardiac monitor to be provided to *[patient’s name]* on *[procedure date]*.

I urge you to reconsider your denial of prior authorization in light of the patient’s specific clinical need, as well as the evidence for this technology.

The FDA approved Insertable Cardiac Monitor is capable of monitoring and performing diagnostic valuation of patients who experience unexplained symptoms that may be cardiac-related such as: dizziness, palpitations, chest pain, syncope, and shortness of breath, as well as patients who are at risk for cardiac arrhythmias such as bradycardia, tachycardia, and sinus pauses. The ICM is also indicated for patients who have been previously diagnosed with atrial fibrillation (AF) or who are susceptible to developing AF. It is intended to be inserted subcutaneously in the left pectoral region, also described as the left anterior chest wall.

*[If applicable]* Documentation by the referring physician, as well as my examination, supports the determination of this patient’s need for insertable cardiac monitor.

*[Insert paragraph explaining, in your own words, why ICM is medically necessary for this patient. Where accurate, consider documenting how the patient’s condition reflects the on-label use of the product; why more extensive interventions are inadequate in light of the patient’s condition; your expectations of the patient’s outcomes without the ICM procedure; how patient’s way of life and/or medical condition has benefited already from the procedure itself]*

I am attaching the patient’s medical record information and letter of medical necessity from my previous request.

*[Include the following statement if additional information is to be attached]*

I have attached *relevant excerpts from the patient’s ongoing medical record, a summary of clinical evidence with references from peer-reviewed medical journals*, etc.

As explained above, I believe the ICM insertion is medically necessary for this patient and as such, this service should be granted coverage and paid for by *(insert name of insurance company)*.

Please let me know if I can provide additional information and thank you for your reconsideration.

Sincerely,

*[Physician’s name and credentials]*

*[Title]*

*[Name of practice]*

*[Street address]*

*[City, State, zip code] [Phone number]*

Enclosures:

*[Patient medical records/chart notes]*

*[FDA Approval letter]*

*[Evidence summary and select literature]*