***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 requirements. It is very important to ensure all information provided to your patient's medical benefit administrator 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 CPT codes that are relevant to your patient's medical benefit administrator's policy.] 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 CPT codes that are relevant to your patient's medical benefit administrator's policy.] for treating lower extremity ischemia based on the following indication-specific criteria provided by your health plan.

[Include the required information needed, which is outlined in your patient's medical benefit administrator's policy. Note that these requirements are subject to change and vary depending on your patient's medical administrator’s policy. Please refer to your patient's medical administrator's policy for a comprehensive list of requirements. Information that may be required: (1) Diagnosis and indication for procedure as listed on your patient's medical administrator's policy; (2) Patient's clinical history; (3) Signs and symptoms; (4) Treatments tried and failed (i.e., Supervised/Structured exercise program, pharmacological therapy, Smoking cessation); (5) Ankle-brachial index (ABI); (6) Imaging results and reports of vascular studies."]

[Additional document may be required to support medical necessity based on the patient condition: (1) for the treatment of claudication: documentation of patient symptoms that affect activities of daily living or quality of life, (2) for the treatment of critical limb ischemia (CLI) / chronic limb-threatening ischemia (CLTI): documentation regarding the nature of critical limb ischemia, ischemic rest pain, non-healing wound, or gangrene.]

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]