**SAMPLE LETTER OF MEDICAL NECESSITY TEMPLATE**

Insertable Cardiac Monitor (ICM)

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

1. Letters of medical necessity are often key to requesting **prior authorization** of procedures.
2. Please customize the medical necessity letter template based on the medical appropriateness. Text requiring customization is in **RED**.
3. After you have customized the letter, ***please make sure to delete this Instructions page and any RED text instructions*** for completion, disclaimers, Abbott logos, caution statement, trademarks and document number that are seen throughout the letter.
4. 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.

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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 Implantable Cardiac Monitor**

Patient name: *[First and last name]*

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

Insurance ID # *[XXXXXXXXXXXXXXX]*

Group # *[XXXXXXXXXX]*

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

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

***CPT Code****: (options shown below)*

* ***33285****, Insertion, subcutaneous cardiac rhythm monitor, including programming*

I am writing on behalf of my patient, [patient’s name], requesting prior authorization for the insertable cardiac monitor. This procedure is scheduled for an [inpatient/outpatient] setting at [facility name] on [planned procedure date]. I have examined this patient and have reached a decision that the device is medically necessary for this patient.

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. It 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.

**Patient Clinical History**

Moreover, a *[state alternative therapy]* is not sufficient for this patient for the following reason(s): *[insert clinical reasons why the ICM is more clinically appropriate, or why other alternatives is a minor or absolute contraindication].*

*Are you requesting an* ***urgent*** *review? Definition of* ***urgent****: When the physician believes that waiting for a decision under the standard time frame could place the patient’s life, health, or ability to regain maximum function in serious jeopardy.*

In closing, I believe the insertable cardiac monitor 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 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:**

*Attach any relevant information, such as*

* *FDA approval letter*
* *Relevant clinical studies / publications*
* *Patient medical records/chart notes documenting all the following required clinical information:*
* *ICD diagnosis and indication for procedure*
* *Relevant history and physical to include patient’s symptoms and pertinent findings*
* *Treatments tried, failed and/or contraindicated, including pharmacologic therapy, if applicable*