Letter of Medical Necessity Template

1. Replace all red highlights with requested information in black.
2. Remove this heading.
3. Print final document on official practice/physician letterhead.

This is being provided solely for informational purposes and for your independent consideration and review. You should make any and all changes that you believe are appropriate, or disregard these suggestions in their entirety. Arthrex makes no assurances that the use of this letter will guarantee coverage or reimbursement of any item or service. The provider of services has the sole responsibility to determine medical necessity and to submit appropriate codes and charges for care provided in accordance with the particular payor(s)' requirements.

<Date>

<Contact Name>
<Title>
<Insurance Company Name>
<Insert Payer Address>

RE: Coverage and reimbursement request for the use of bone marrow aspirate and platelet-rich plasma for the treatment of <injury>.
<Patient Name>
<Patient's Date of Birth>
<Patient's Insurance Policy Information>

Dear <Contact Name>,

I am writing on behalf of my patient to document the medical necessity for the use of bone marrow aspirate (BMA) mixed with demineralized bone matrix and platelet-rich plasma concentrate (cPRP) for the treatment of <list condition here>. This surgical technique is for the treatment of bone pathologies resulting from acute or chronic injury, including bone marrow lesions associated with insufficiency fractures, persistent bone bruises, osteoarthritis, and early stages of avascular necrosis. The procedure involves performing a core decompression of the lesion and a direct application of cPRP from BMA and is coded as the following:

HCPCS Code(s):
Long Descriptor:
Short Descriptor:

CPT Code (s):
Long Descriptor:
Short Descriptor:

This patient suffers from <describe injury>. A copy of their most recent medical record is enclosed for your review. I believe my patient is an appropriate candidate a direct application of cPRP from BMA because: Insert paragraph(s) regarding patient's pertinent medical history information, including:

- Duration of related symptoms
- Prior failed conservative treatments
- Impact on patient's quality of life
- Surgical risk factors such as age, obesity, or other health issues
- Describe anticipated outcome without treatment and medical benefit of desired treatment base on clinical points supported in the literature

I have evaluated and counseled my patient on various treatment options based on their clinical presentation and failure to find respond to conservative interventions outlined above. In summary, this procedure is

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medically necessary for my patient's medical condition. Please contact me if any additional information is required to ensure the prompt approval.

Sincerely,

<Physician's Name >
<Physician Signature>

Enclosures: Medical Records