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: Letter of Medical Necessity for osteochondral defect repair as treatment for <List condition here>.
<Insert Patient Name>
<Insert Patient's Date of Birth>
<Insert Patient's Insurance Policy Information>

Dear <Contact Name>,

I am writing on behalf of my patient to document the medical necessity for the repair of a symptomatic articular cartilage defect due to <list condition here>. This surgical technique is a single-stage, matrix-augmented, autologous chondrocyte transplantation that combines articular autologous cartilage tissue harvested during the procedure mixed with an extracellular matrix to fill the defect.

Mr./Ms. <Insert patient's last name> suffers from <List condition here>. A copy of their most recent medical record is enclosed for your review. Please find below a summary of why my patient is an appropriate candidate for autologous chondrocyte transplantation that combines articular cartilage with an extracellular cartilage matrix.

Insert paragraph(s) regarding patient's pertinent medical history information to include:

- 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

The procedure is coded as the following:

- < CPT Code(s):>
- < HCPCS Code(s):>

I have evaluated and counseled my patient on various treatment options based on their clinical presentation and failure to find respond to the conservative interventions outlined above. In summary, autologous chondrocyte transplantation that combines articular cartilage with an extracellular matrix is medically

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necessary for this patient's medical condition. Please contact me at <requesting physician's direct telephone number> if any additional information is required to ensure the prompt approval.

Sincerely,

<Physician's Name >
<Physician's Signature>

Enclosures: <Supporting Literature>