

Pre-Determination Sample Letter

<INSURANCE COMPANY>

<INSURANCE ADDRESS>

<CITY, STATE, ZIP CODE>

Attn.: Pre-Determination Dept

<DATE>

Re: Letter of Medical Necessity

Patient/ID #: <PATIENT NAME>, <IDENTIFICATION #>

DOS: <DATES(S) OF SERVICE>

ICD-9-CM: <LIST THE DIAGNOSIS CODE THAT APPLIES TO THE PATIENT – SOME RELEVANT CODES ARE: 715.16, 715.26, 715.36, AND 715.96>

To whom it may concern,

I am requesting approval for the medically necessary use of *Gel-One* Hyaluronate, a derivative of sodium hyaluronate for <diagnosis> for my patient, <Patient Name>, as referenced above. *Gel-One* Hyaluronate, a viscosupplement treatment is indicated for the treatment of pain associated with osteoarthritis (OA) of the knee. *Gel-One* Hyaluronate supplements the naturally occurring synovial fluid providing pain relief and improved knee function. It helps get patients back to what matters most, living life. This letter provides information about the patient's medical history and diagnosis, treatment summary, and a copy of the package insert. *Gel-One* Hyaluronate will be billed using the HCPCS J-code J7326 (Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose).

<Patient name> was diagnosed with osteoarthritis on <date>. < Discuss any current and previous therapies to treat this patient.> <Discuss patient's symptoms (e.g. Pain)>. The most recent examination on <date> revealed <results of exam>. <Discuss the reason for *Gel-One* Hyaluronate>.

Osteoarthritis is one of the most frequent causes of physical disability among adults, and the knee is one of the most commonly affected joints. This is a painful condition that affects millions of Americans and can make walking, climbing, and other daily activities difficult. In severe cases, osteoarthritis of the knee may require surgery. *Gel-One* Hyaluronate is a highly purified, low volume (3ml), single viscosupplement injection. *Gel-One* Hyaluronate was

approved by the FDA on March 22, 2011 for marketing as a medical device. *Gel-One* Hyaluronate is indicated for treatment of pain in osteoarthritis of the knee in patients who have failed to respond adequately to conservative nonpharmacologic therapy, nonsteroidal anti-inflammatory drugs (NSAIDs) and to analgesics.

Enclosed are copies of <patient>'s medical records documenting their diagnosis (attached). I believe *Gel-One* Hyaluronate therapy is medically necessary for this patient. Please approve *Gel-One* Hyaluronate treatment for <patient>.

If you have any further questions regarding this matter, please do not hesitate to call. Thank you for your prompt response to this matter.

Sincerely,

<PHYSICIAN NAME> M.D.

Enclosure options:

Package Insert

Clinic notes and x-ray reports/flow sheet

Medical Records supporting medical necessity

Supportive Medical Literature