**SAMPLE LETTER OF MEDICAL NECESSITY REQUESTING**

**PRE-AUTHORIZATION OF PROGRAMMING SERVICES FO**R **rem**ed­ē **THERAPY**

**(NOT INCLUDING SEPARATELY IDENTIFIABLE E/M CODE(S) FOR CLINIC VISIT(S))**

**DISCLAIMER:** This sample template letter is provided as a courtesy by ZOLL Respicardia. Please do not include statements that do not apply to your patient, and edit this letter to fit your unique experience. ZOLL Respicardia is not responsible for any edits made to the letter, makes no representations or warranties with respect to the contents of this letter, and disclaims any liability associated with the use of this letter. You are responsible for providing true, accurate, and complete information concerning the applicable diagnosis and procedure codes and the patient’s medical record, and ensuring the medical necessity of the procedure or clinic visit.

This document is for informational purposes only and is not legal advice or official guidance from payors. It is not intended to increase or maximize reimbursement by any payor. Hospitals and physicians are solely responsible for being in compliance with Medicare and other payor rules and requirements for the information submitted with all claims and appeals. ZOLL Respicardia does not warrant or guarantee that the use of this information will result in coverage or payment. Before any claims or appeals are submitted, hospitals and physicians should review official payor instructions and requirements, should confirm the accuracy of their coding or billing practices with these payors and should use independent judgment when selecting codes that most appropriately describe the services or supplies provided to a patient. Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. ZOLL Respicardia recommends that you consult with your payers, reimbursement specialists and/or legal counsel regarding coding, coverage and reimbursement matters.

**Instructions for completing the sample appeal letter:**

1. Please customize the appeals template based on the medical appropriateness of the **rem**edē® System for your patient. Fields required for customization are **highlighted in red text**.
2. It is important to provide the most complete information to assist with the appeals process.
3. After you have customized the appeals letter, please make sure to delete any specific instructions for completion that are in red text throughout the letter so the health plan does not misinterpret this as a form letter.

If you have questions, please contact 1-952-540-4470 or email reimbursement@remede.zoll.com.

[Date]

**To:** [Insurance Company PA/Pre-D Dept]

[Address]

[City, State, Zip]

**Re: Request For Pre-Service Approval for Programming of the rem**ed­ē **Transvenous Phrenic Nerve Stimulation System for Central Sleep Apnea (“rem**ed­ē **System”)**

**Patient Name: [Patient name]**

**Date of Birth: [Date of Birth]**

**Group/Policy Number: [Policy #]**

**CPT® Code:** *CPT 93151, Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; single session*

**Diagnosis Code: Central Sleep Apnea, G47.31**

**Initial implant Surgery Approval Code: [Authorization code]**

**Implant Surgery DOS: [Date of implant surgery]**

Dear Medical Reviewer,

I am writing to request authorization by [Insurance Company name] in order to perform services related to [Therapy Activation] or [Therapy Optimization] of the **rem**edē System. The **rem**edē System is an implantable system that safely and effectively treats moderate to severe Central Sleep Apnea (CSA) in adult patients. The coverage for placement of the **rem**edē System (CPT code 33276) was approved on [Date of approval of implant surgery] and the authorization code for the initial surgery is [insert initial implant auth code]. The surgery to implant the **rem**edē System was performed by Dr. [Last name of implanting surgeon] on [Date of Implant surgery] at [Name of Facility].

As demonstrated in the pivotal trial[[1]](#footnote-1), the **rem**edē system requires [therapy activation -or- intermittent device interrogation] to optimize the therapy and clinical outcomes. It is my clinical judgement that [patient name] now requires a therapy review as part of their treatment plan for this implantable device. This session includes review of device data, programming and adjusting device stimulation, and patient education. Pursuant to the requirements of FDA approval, I have received specialized training related to all aspects of therapy management including the initiation of therapy, titration, and use of the programmer.

Thank you for your time and consideration. Please notify me if additional information is required by calling me at [insert phone number].

Sincerely,

Provider Name

NPI:

Address

City, State ZIP

Contact Phone Number

**Enclosures:**

IFU

Implant procedure Prior Authorization Approval Letter

1. Costanzo MR, Ponikowski P, Javaheri S, et al. Transvenous neurostimulation for central sleep apnea: a randomised controlled trial. *Lancet*. 2016;388(10048):974–982. [↑](#footnote-ref-1)