

SAMPLE LETTER OF MEDICAL NECESSITY/APPEAL OF CLAIM DENIAL

<date>

<Insurance company name>

<insurance company address>

Re: Payment for Intravascular Ultrasound Evaluation of <insert diagnosis>

Patient Name: <patients name>

Insurance ID: <patient's insurance ID number>

Dear Sir or Madam,

I am requesting professional fee payment for clinical services described by CPT 37252: *Intravascular ultrasound during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial non-coronary vessel* <if used, also insert **“and CPT 37253: Intravascular ultrasound during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional non-coronary vessel”**>.

My patient.....<insert case notes as appropriate to support diagnosis and treatment>

There is a growing body of evidence suggesting the clinical benefits of using IVUS in diagnosing arterial disease. According to published medical literature, IVUS, used as an adjunct to angiography during endovascular peripheral arterial interventions has been associated with better outcomes compared to procedures guided by angiography alone. Angiography provides imaging of the arterial lumen; however, angiographic evaluation of true vessel diameter, luminal area stenosis, plaque concentricity, and calcification may be extremely discordant when compared to IVUS. Additionally – due to its cross-sectional nature – IVUS imaging is capable of more complete visualization of vessel wall and lesion morphology (e.g., dissection, calcium distribution, stent malapposition, medial/adventitial damage) which may identify factors other than luminal narrowing that may affect treatment decisions in real-time. Potential limitations of IVUS use in PAD include acoustic shadowing due to heavily calcified lesions, increased cost and time associated with the use of an additional device, and the training required to become familiar with IVUS image interpretation. Nevertheless, current clinical evidence regarding endovascular treatment of PAD supports a conclusion that IVUS-guided intervention may result in better technical and clinical outcomes than procedures guided by angiography alone. A recently published retrospective study¹ reported on data from 1198 limbs (965 patients) with TASC II A-C femoropopliteal lesions (28% CLI) and compared primary patency rates of IVUS vs. non-IVUS guided procedures in 234 propensity score matched pairs. Of the 1198 procedures, IVUS was used in 22% (n=268) and was more likely to be used in cases with more complicated femoropopliteal lesions (e.g., more severe TASC II class, longer lesion length, and narrower reference diameter). Furthermore, analysis of the 234 propensity score-matched pairs (mean follow-up 1.9±1.5 years; 142 events) revealed that IVUS use was associated with higher 5-year primary patency than without (65 ± 6% vs. 35 ± 6%, p<0.001) and was associated with significantly better assisted primary patency (p<0.001), secondary patency (p=0.004), freedom from any re intervention (p<0.001), freedom from any adverse limb event (p<0.001), and event-free survival (p<0.001). A cohort study² examined the impact of intravascular ultrasound (IVUS) utilization during lower limb endovascular interventions as regards post-procedural complications and amputation in 92,714 patients extracted from the Healthcare Cost and Utilization Project Nationwide Inpatient Sample database between the years 2006 and 2011. IVUS was used in 1,299 (1.4%) patients. The authors found that IVUS utilization during lower extremity peripheral vascular procedures was independently predictive of a lower rate of post-procedural complications (OR 0.80, 95% CI 0.66 to 0.99, p=0.037) as well as lower amputation rates (OR 0.59, 95% CI 0.45 to 0.77, p<0.001) without any significant impact on in-hospital mortality. Multivariate

analysis also revealed IVUS utilization to be predictive of a non-significant increase in hospitalization costs (\$1333, 95% CI -\$167 to +\$2833, p=0.082).

I hope the information in this letter has clarified why, based on published scientific evidence and in my clinical opinion, the use of IVUS was medically necessary for appropriately diagnosing and guiding the treatment of my patient's <insert diagnosis>. I respectfully request that this claim be approved for payment. If you require any additional information, please feel free to contact me at the address and telephone number below.

Best Regards,

<Treating Physicians Name>

<Treating Physicians Address>

<Treating Physicians Telephone>

¹ Lida O, Takahara M, Soga Y, Suzuki K, Hirano K, Kawasaki D, Shintani Y, Suematsu N, Yamaoka T, Nanto S, Uematsu M. Efficacy of intravascular ultrasound in femoropopliteal stenting for peripheral artery disease with TASC II class A to C lesions. J Endovasc Ther 2014;21(4):485-92.

² Panaich SS, Arora S, Patel N, Patel NJ, Savani C, Patel A, Thakkar B, Singh V, Patel S, Patel N, Agnihotri K, Bhatt P, Deshmukh A, Gupta V, Attaran RR, Mena CI, Grines CL, Cleman M, Forrest JK, Badheka AO. Intravascular ultrasound in lower extremity peripheral vascular interventions: variation in utilization and impact on in-hospital outcomes from the nationwide inpatient sample (2006-2011). J Endovasc Ther 2016;23(1):65-75.