

Sample Letter for Commercial Payor Prior Authorization

Letter for Office or Hospital Setting for PROSTIVA RF Therapy Procedures

Date:

Patient:

Inside Address

Policy Holder:

ID/Soc. Security #:

Dear _____:

The purpose of this letter is to request a predetermination of coverage/prior authorization for the use of Medtronic's PROSTIVA® RF Therapy (Transurethral destruction of prostate tissue; by radio frequency thermotherapy) for the treatment of symptomatic benign prostatic hyperplasia (BPH).

BPH is a non-malignant growth of the prostate that obstructs urine flow and can cause other urological symptoms such as urgency, frequency and nocturia. Symptoms may include pain, burning sensation during urination, hesitancy, post-void residual, straining, weak stream and overflow incontinence. If drug therapies fail, other invasive treatment options must be considered to relieve patient symptoms.

PROSTIVA RF Therapy is a minimally invasive treatment for symptomatic benign prostatic hyperplasia (BPH) that received FDA 510(K) clearance in 2005. RF therapy for symptomatic BPH, first cleared by the FDA in 1996, offers a cost-effective and quality-of-life enhancing alternative to the more invasive surgical procedure, transurethral resection of the prostate (TURP). Following the PROSTIVA RF Therapy procedure, most men return to their normal lifestyles within a few days.

[Select one of the following sections, depending on whether the procedure will be performed in an office or hospital setting:]

[For Office Procedures:]

I intend to perform this procedure in my office. The PROSTIVA RF Therapy procedure is accomplished by administration of low-level radiofrequency energy to ablate excess prostate tissue contributing to these urological symptoms, with the goal of improving urine flow. This procedure is effective and has the product features to protect the urethra. The PROSTIVA RF Therapy procedure can be performed in the office setting, eliminating hospital expenses.

The 2008 Medicare national average non-facility physician rate of \$2,960 (Geographic Practice Cost Indices apply) became effective January 1, 2008. This RVU information was published in the CMS Final Rule of the Physician Fee Schedule (Federal Register, Volume 72, No. 227/ November 27, 2007/Rules and Regulations). The Medicare Physician Fee Schedule conversion factor for 2008 is \$38.0870 as published by CMS in the "Revisions to Payment Policies under the Physician Fee Schedule for CY 2008" and amended by the Medicare, Medicaid and SCHIP Extension Act of 2007, Title I - Medicare, Sec. 101, December 29, 2007.

[For Hospital Procedures:]

I intend to perform this procedure at [facility name]. Medicare coverage has been established in most states. The CPT/HCPCS code used to report the PROSTIVA RF Therapy procedure is 53852. Please reference the Federal Register/Volume 72, No. 227, dated November 27, 2007 for 2008 APC payment levels. The final rule assigns Prostiva to APC 0429 with a national average payment rate of \$2,879. As is customary, there are geographic adjustments, which will affect hospital-specific payment. The Medicare 2008 national average payment to the physician in the facility site of service for 53852 is \$595. The RVU information was published in the November 27, 2007 Federal Register with a conversion factor is \$38.0870 as amended by the Medicare, Medicaid and SCHIP Extension Act of 2007, Title I - Medicare, Sec. 101, December 29, 2007.

[The following section applies to either type of letter]

Based on my review, I believe that my patient, *[patient's name]*, is an excellent candidate for this therapy. *[Personalize the letter for the particular patient using the information outline that follows. You may require one or more paragraphs for each of the headings listed.]* Address each of the following points in the body of the letter or in an attached report:

Document Current Findings/Status

Describe the patient's current status, including diagnosis, complaints, and level of impairment. Detail functional impairment, and state how quality of life, activities of daily living, caregiver activities (if applicable), employment, etc., are affected. Consult applicable coverage policy or Medicare Local Coverage Determination (LCD) for coverage criteria.

Document Chronological History

Describe the patient's history and treatment, noting the symptoms (when they started), any prior diagnosis (when), procedures/interventions, drug therapies (type of drugs, when). Note the outcome of each.

Recommend PROSTIVA RF Therapy

State how this therapy is an appropriate intervention at this point in the patient's care. Note that you expect to see an improvement in urinary symptoms. Note therapeutic goals, anticipated outcome, risk of performing the procedure, risks of not performing the procedure, and possible complications.

*I believe that PROSTIVA RF Therapy is medically necessary for *[patient's name]*. I request confirmation that this therapy is a covered benefit based on medical necessity, and that associated non-facility professional fees for the testing, treatment application, and follow-up will be covered. I request authorization for procedure code 53852 including the physician non-facility *[or facility if procedure will be hospital-based]* professional payment level that I can expect from *[name of commercial payer]*. In addition, there will be diagnostic procedures performed in my office prior to the PROSTIVA RF procedure that may be billable in addition to the 53852 procedure. These procedures are recognized for diagnosis of BPH or may be necessary to provide clinical data for use during the procedure. They may include:*

- CPT 992XX: Office visit/office consult
- CPT 76872: Ultrasound, Transrectal
- CPT 84153: Prostate Specific Antigen (PSA)
- CPT 81000: Urinalysis (UA)
- CPT 51741: Electro Uroflowmetry
- CPT 52000: Cystoscopy

*My office will contact you next week to discuss any questions you may have about the therapy. I have tentatively scheduled this procedure to be performed on *[date]*. Thank you for your review of this information and for your coverage consideration. If you have any questions, please contact me at *[phone]*.*

Sincerely,

[Physician's name], M.D.

cc: [Hospital Administrator] (if applicable)