[Date]

[Health Plan Name]

[Address]

RE: [Patient's Name/Policy Number]
Coverage of the ProDisc-L™ artificial lumbar disc

Dear Dr.

I am writing to justify coverage for lumbar disc arthroplasty using the ProDisc-L™ artificial disc.

[Patient's Name] suffers from [insert patient diagnosis]. A copy of her most recent medical record is enclosed for your review. I strongly believe that this patient's condition and medical history make him an appropriate candidate for lumbar disc arthroplasty. This procedure is medically necessary and warrants coverage given Mr. MS medical history.

History:

[Note patient's previous treatment, how long the patient has had symptoms and how these symptoms have affected his/her quality of life.]

I will be submitting CPT Code 22857: total disc arthroplasty, lumbar, when billing for the procedure. My fee for this procedure represents the time, skill and overhead associated with performing the total disc arthroplasty, total discectomy, preparation of the interbody space, exposure of the posterior longitudinal ligament and removal of the cartilaginous endplate followed by insertion of the ProDisc artificial disc.

Enclosed you will find clinical and technical information outlining the safety and efficacy of lumbar disc arthroplasty using the ProDisc-L artificial disc. I believe this information paired with the patient's medical record substantiate coverage and payment for the procedure. I request confirmation that lumbar disc arthroplasty is a covered benefit based on medical necessity, and that associated professional fees for treatment will be covered.

If you require additional information, please contact me at [insert telephone number]. Thank you for your timely response.

Sincerely,
(Physician Name)

Enclosures:
FDA Approval Letter
Summary of Safety and Effectiveness
Patient Medical History