NOTE TO PHYSICIAN: This sample letter is not meant to be used as a form letter. You should customize the letter to reflect the particular background, medical history and diagnosis of the specific patient, as well as any special requirements of the payer involved. 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.

SAMPLE PRIOR AUTHORIZATION LETTER
IMPLANT ONLY AFTER TRIAL COMPLETED

Attention: Surgery Preauthorization Department
[Insurance Company] Via Facsimile Transmission

Patient Name: _____
Patient ID: _____

Dear Sir/Madam:

This letter is to request approval for the surgery, hospitalization, and post-surgical care needed for the implantation of a spinal cord stimulator system for (patient name). This patient is scheduled for outpatient surgery on [date].

Spinal cord stimulation works by sending electrical impulses to the spine cord. The impulses block the pain signals from reaching the brain, and replace the pain sensations with a paresthesia (tingling) feeling. Unlike corrective surgeries, stimulation is non-destructive and reversible. With stimulation, patients may experience pain reduction, improved activities of daily living, independence, and less need for oral medications to manage pain. The efficacy, safety and cost-effectiveness of spinal cord stimulation has been established in the medical literature for over 25 years, and the procedure is covered nationally by many payers, including Medicare. We request approval for a Spinal Cord Stimulation System, made by Boston Scientific Neuromodulation Corporation.

Previously, you approved the Phase I trial to evaluate potential efficacy of this treatment. Please see the attached Phase I progress notes. [Or, insert date, number of days, and brief description of trial and outcome here.]

Based on the outcome of the Phase I trial, the patient will receive permanent implantation of the stimulator. Specifically, this patient will receive a Spinal Cord Stimulator System, made by Boston Scientific Neuromodulation Corporation. This SCS System includes a re-chargeable battery within the implanted stimulator, allowing the physician and patient to control pain at the most optimal settings without compromising battery life compared to non-rechargeable SCS systems. The Boston Scientific SCS System is FDA-approved.

[*Instruction to physician: Choose appropriate codes to be billed for professional and facility services and include in your letter.*]

Code	Phase II (Permanent) Implantation*	Units
☐ 63650	Percutaneous implantation of neurostimulator electrode array, epidural	
☐ 63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	
☐ 63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	
☐ 95972	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour	
☐ 95973	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)	

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Code	Phase II (Permanent) Implantation*	Units
☐ L8679**	Implantable neurostimulator pulse generator, any type	
☐ L8680	Implantable neurostimulator electrode, each	
☐ L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only	
☐ L8687**	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension	
☐ L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only	
☐ L8699	Prosthetic implant, not otherwise specified	

**The provider is responsible for verifying payer policy as to the appropriate code used for describing each type of implantable pulse generator.

Estimated charges for this surgical procedure, including device and associated medical, surgical and follow up care total approximately $_____, depending on patient need. The patient will usually be in the hospital for less than 24 hours with outpatient observation status.

Please provide authorization for this procedure as soon as possible, so that this patient can begin experiencing relief from debilitating chronic pain.

If you have questions or need further information, please contact me.

Sincerely,

[Physician Name]
[Practice Name]
[Phone Number]

Enclosures: [Phase I Progress Notes]