**Sample Letter of Medical Necessity (Expanded Version)**

*(For Predetermination of Coverage – Skin Substitute Application in Wound Care)*

**[Date]**

**To:**  
Medical Director / Utilization Review Department  
[Insurance Company Name]  
[Insurance Company Address]

**Re:** Request for Predetermination of Coverage – Skin Substitute Application  
**Patient:** [Patient Name], DOB: [MM/DD/YYYY]  
**Insurance ID #:** [Member ID]  
**Provider:** [Provider Name, Credentials]  
**Practice/Facility:** [Practice/Facility Name]  
**Tax ID / NPI:** [Provider Tax ID / NPI]

**Clinical Summary**

[Patient Name] is a [age]-year-old [male/female] with a history of [diabetes, peripheral vascular disease, venous insufficiency, etc.]. The patient has been under our care since [date] for management of a **[wound type: diabetic foot ulcer / venous leg ulcer / pressure ulcer]** located on the **[anatomic location]**.

The wound has persisted for **[X weeks/months]** despite appropriate standard of care, including:

* Regular wound cleansing and sharp debridement
* Moist wound dressings
* Offloading or compression therapy (as clinically appropriate)
* Infection control and glycemic/nutritional optimization
* Close monitoring and documentation of healing progress

Current wound status:

* **Length:** [cm]
* **Width:** [cm]
* **Depth:** [cm]
* **Surface area:** [sq cm]
* Tissue quality: [granulation/slough/necrosis %]
* Drainage/Exudate: [minimal/moderate/heavy]

**Relevant Comorbidities and Systemic Conditions**

The patient’s comorbid conditions and overall health status directly impact wound healing potential:

* **Diabetes mellitus:** Most recent HbA1c **[X.X%]** (date). Patient demonstrates **[neuropathy, nephropathy, retinopathy]**. Glycemic control remains suboptimal despite ongoing management with [endocrinology/primary care].
* **Vascular status:** Most recent ABI **[value]** (date). Doppler/vascular study shows **[adequate perfusion / mild-moderate arterial insufficiency]**, confirming viability for healing but with increased risk for delayed closure.
* **Nutritional status:** Albumin **[g/dL]**, BMI **[value]**. Findings indicate **[normal/mild malnutrition/moderate malnutrition]**, which contributes to impaired tissue repair.
* **Other comorbidities:** [e.g., chronic kidney disease, venous insufficiency, history of smoking].

These systemic risk factors have been addressed in the care plan, but they continue to impair the natural healing process, making advanced biologic therapy medically necessary.

**Medical Necessity for Skin Substitute**

The wound has failed to progress despite [X weeks/months] of comprehensive wound care. Given the chronicity, comorbid conditions, and high risk of complication, the application of a skin substitute ([Product Name, CPT code]) is required to stimulate healing.

Without advanced treatment, the patient is at increased risk of:

* Worsening infection (cellulitis/osteomyelitis)
* Chronic pain and impaired mobility
* Possible hospitalization and/or limb amputation
* Increased overall healthcare costs

**Requested Treatment**

We are requesting approval for **[X applications]** of **[Product Name]** (CPT [code]) for the treatment of **[diagnosis, ICD-10 code(s)]**.

This therapy will be combined with ongoing standard wound care practices (debridement, dressing changes, offloading/compression, infection control, and comorbidity management).

**Supporting Documentation**

Attached for review:

1. Wound care progress notes and weekly measurements
2. Debridement and treatment history
3. Recent wound photographs
4. Lab values (HbA1c, albumin, BMI) and vascular assessment results
5. Clinical guidelines and supporting literature

**Conclusion**

In summary, [Patient Name] has a **chronic, non-healing wound** that has failed to respond to standard wound care. Their comorbidities, including [list key ones], increase risk of complications and justify the need for a skin substitute. Application of [Product Name] is **medically necessary, appropriate, and in line with clinical guidelines** to promote wound healing, reduce complications, and improve quality of life.

Because this service is covered under Original Medicare, your Medicare Advantage plan is required by federal law to provide the same level of coverage\*. This ensures that Medicare Advantage members are entitled to all medically necessary benefits available under traditional Medicare.

We respectfully request **predetermination and approval** for this treatment.

Thank you for your review and consideration. Please contact me directly with any questions or additional requests.

Sincerely,  
[Provider Name, Credentials]  
[Title/Position]  
[Practice/Facility Name]  
[Phone]  
[Fax]

\**Pursuant to Section 1852(a)(1)(A) of the Social Security Act (42 U.S.C. § 1395w-22) and its implementing regulation at 42 C.F.R. § 422.101(a), Medicare Advantage (MA) plans are required to furnish enrollees with all services covered under Medicare Parts A and B, other than hospice care. The requested service/procedure is a covered Medicare Part A and/or Part B benefit and must be provided accordingly.”*