MAC00161-01, Rev H; Sample Letter of Appeal Due to Denial for Medical Necessity

[Date]

Re: [Insert Patient Name] [Insert Patient ID #]

 [Insert Claim # or Reference #] [Insert Patient DOB]

 [Insert Date of Service]

Dear [Name of Medical Director or insurance company]:

I am requesting reconsideration of the above referenced denial for lack of medical necessity. Prostatic urethral lift (PUL) using the UroLift® System has been cleared for use by the FDA since 2013. The UroLift System is currently indicated for the treatment of symptoms due to urinary outflow obstruction secondary to benign prostatic hyperplasia (BPH), including lateral and median lobe hyperplasia, in men 45 years of age or older. The American Urological Association (AUA) develops scientifically rigorous, peer-reviewed guidelines in their mission to promote the highest standards of urological clinical care. The 2018 update to their Guidelines on the Surgical Management of Lower Urinary Tract Symptoms Attributed to Benign Prostate Hyperplasia positions the PUL procedure (using the UroLift System) as part of the standard of care alongside TURP, laser, and other established procedures. The current peer-reviewed, published scientific literature is more than adequate to establish the clinical utility, safety, and efficacy of this minimally invasive treatment for BPH. The UroLift System is a covered procedure under this patient’s plan, and the PUL procedure was medically necessary for this patient.

For medically appropriate patients, like Mr. [insert patient last name], PUL provides unique and necessary benefits that are both rapid acting and durable. PUL was medically necessary for this patient due to his urinary symptoms caused by BPH. [Describe how the patient meets the medical necessity criteria outlined in the plan’s policy, such as:

* Duration of medical therapy and why it failed or why it was not tolerated by the patient
* Prostate size
* Patient’s anatomy including a normal bladder neck
* PSA and/or prostate cancer screening
* Patient did not have an active UTI, prostatitis, retention, gross hematuria, etc.
* Patient has no known nickel allergy
* See the relevant medical policy or UroLift System state coverage profile for an accurate listing of criteria]

Not treating or delaying treatment of BPH can result in eventual deterioration of bladder function, urinary retention, recurring urinary tract infection and deterioration in quality of life.

The PUL procedure using the UroLift System has been well-studied in high quality trials and is the subject of over 25 peer-reviewed publications, describing two separate RCTs, three meta-analyses, and multiple open label studies. All studies show consistent, reliable, and durable improvements in urinary symptoms and quality of life, no instances of new, sustained erectile or ejaculatory dysfunction, and reduced recovery time and morbidity compared to alternative treatment options. The PUL procedure also does not require an overnight stay, can be conducted under local anesthesia, in many cases can be done in the office, shows patients typically return to preoperative activity in under a week and have reduced post-operative catheterization rates compared to alternative interventions, all while avoiding potential complications associated with other BPH treatments such as permanent incontinence, erectile dysfunction, strictures or bladder neck contracture. The transient adverse events associated with PUL, including mild to moderate hematuria, dysuria, micturition urgency, pelvic pain and urge incontinence, typically resolve on their own within two to four weeks.

In summary, the PUL procedure has been well-studied and reported in numerous high quality, peer-reviewed publications. Objective results demonstrate that the PUL procedure offers reliable, repeatable results including rapid relief from symptoms, increased urinary flow, and improvement in quality of life that are durable to at least five years. Based on the information provided here and your own medical policy, it is clear that PUL is broadly accepted as an appropriate treatment option in the urology community and was medically necessary for this particular patient. Please reconsider this request for coverage and payment at your earliest convenience or contact me at [phone number] if I can provide additional information.

Sincerely,

[Physician’s name]

Enclosures:

Copy of EOB

Pertinent Medical Records

Link to AUA Guideline: [https://www.auanet.org/guidelines/benign-prostatic-hyperplasia/lower-urinary-tract-symptoms-(2018)](https://www.auanet.org/guidelines/benign-prostatic-hyperplasia/lower-urinary-tract-symptoms-%282018%29)