

**Date:** [Date]

**TO:** [Insurance Company Name]

**ATTN:** Prior Authorization/Medical Review Department

**FAX/ADDRESS:** [Fax Number or Address]

**RE:** Letter of Medical Necessity for Magnetic Resonance (MR) Arthrogram

**Patient Name:** [Patient First and Last Name]

**Date of Birth:** [Patient DOB]

**Policy Number:** [Insurance Policy Number]

**Group Number:** [Group Number]

**Claim/Reference Number:** [Reference Number if applicable]

To Whom It May Concern,

I am writing to request a formal review and authorization for a **Magnetic Resonance (MR) Arthrogram of the [Left/Right] Shoulder (CPT Code: 73222/73223 and 23350)** for the above-mentioned patient.

**Clinical Diagnosis:**

The patient presents with [List Diagnosis, e.g., Suspected Labral Tear, SLAP Lesion, Chronic Shoulder Instability, or Recurrent Rotator Cuff Tear]. (ICD-10 Code: [Insert Code])

**Clinical History and Findings:**

The patient has been experiencing symptoms since [Date/Timeline]. Physical examination findings include [List findings, e.g., positive O'Brien's test, positive apprehension test, decreased range of motion, or persistent pain].

**Previous Treatments:**

The patient has attempted and failed conservative management, including:

- Physical Therapy: [Duration/Dates]
- NSAIDs/Medications: [List Medications and Duration]
- Corticosteroid Injections: [Dates]
- Activity Modification: [Duration]

Despite these interventions, the patient continues to experience functional impairment and pain.

**Medical Necessity:**

A standard MRI without contrast was [inconclusive / not performed because an MR Arthrogram is the gold standard for this specific pathology]. The intra-articular injection of contrast is medically necessary to distend the joint capsule and provide the high sensitivity required to identify [specific pathology, e.g., a non-displaced labral tear] which cannot be adequately visualized on a non-contrast study. This imaging is essential to determine if surgical intervention is required.

Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

[Physician Signature]

**[Physician Name, MD/DO]**

[NPI Number]

[Practice Name]