

**Date:** [Date]

**RE:** Letter of Medical Necessity for Compression Garments

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Date of Birth]

**Policy Number:** [Policy Number]

**Group Number:** [Group Number]

To Whom It May Concern,

I am writing to formally document the medical necessity of medical-grade compression garments for my patient, [Patient Name], who is currently under my care for the treatment of Postural Orthostatic Tachycardia Syndrome (POTS), ICD-10 code G90.a.

POTS is a form of dysautonomia characterized by an excessive increase in heart rate upon standing and significant peripheral blood pooling. [Patient Name] suffers from debilitating symptoms including orthostatic intolerance, syncope (fainting), near-syncope, severe dizziness, and extreme fatigue.

To manage these symptoms and prevent life-threatening falls or injury, I have prescribed medical-grade compression garments with a pressure rating of [e.g., 20-30 mmHg or 30-40 mmHg]. These garments are essential to:

- Provide external pressure to the lower extremities and/or abdomen to minimize venous pooling.
- Increase stroke volume and improve venous return to the heart.
- Regulate heart rate and stabilize blood pressure during postural changes.
- Reduce the frequency of syncopal episodes.

I have prescribed the following specific items:

[Quantity and Description, e.g., 3 pairs of Waist-High Compression Stockings]

These garments are not for comfort or convenience; they are a primary therapeutic intervention required for the daily management of this chronic cardiovascular condition. Failure to use these garments may lead to a significant decline in the patient's functional status and increased emergency room visits.

Please approve coverage for these medically necessary items. If you require further documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Clinic Name]

[Address]