<Date>

ATTN: <Medical Director/ Physician Name>, M.D.

 <Institution/Insurance Company>

 <Street Address>

 <City>**,** <State>, <Zip>

RE: <Patient Name>

DOB: <MM/DD/YYYY>

Member ID: <Insurance ID Number>

Group #: <Enter Group #>

Dear Medical Director:

I am writing this letter on behalf of my patient <patient name> to request coverage for

autosomal dominant polycystic kidney disease (ADPKD) testing. This letter documents the medical necessity for genetic testing to confirm the diagnosis of ADPKD and provides information about the patient’s medical history and treatment.

ADPKD is the most common inherited kidney disease in the United States, affecting more than 500,000 people.[[1]](#footnote-1) The diagnosis of ADPKD relies principally upon imaging of the kidney and a positive family history. However, the diagnosis is often ambiguous in young patients, in whom renal imaging may be inconclusive, or when the family history is unknown.1 Genetic testing may provide valuable information about the cause of the patient’s symptoms when the patient does not fit the customary clinical criteria for the disease or in the absence of a family history of PKD.1

**Patient History and Diagnosis:**

<Patient Name> is a <age> year old <gender > with a suspected diagnosis of ADPKD due to the following symptoms and clinical findings.

1. <Symptom #1 with ICD code>

2. <Symptom #2 with ICD code>

3. <Symptom #3 with ICD code>

4. <Symptom #4 with ICD code>

Renal transplantation is the optimal treatment for ADPKD and affected individuals are excellent transplant candidates.[[2]](#footnote-2) In most cases, the best organ donor for PKD patients is a living relative, increasing the likelihood of preemptive transplantation, prolonged graft and recipient survival, and better immunologic matching.1Genetic testing is essential when renal donation is being considered in a living related donor before the age of 30 years, particularly for PKD2 patients in whom the sensitivity of age-specific cystic renal phenotype is only 67%.1

I am requesting that <patient name> be approved for the Complete PKD Evaluation #761 through Athena Diagnostics, Federal Tax ID #: 31-1805826 /

NPI #:1023063062with the following CPT code(s): 83891(1), 83896(44), 83898(84), 83900(1), 83901(42), 83904(76), 83909(1), 83914(44), 83912(1).

I am specifying Athena Diagnostics to perform the ADPKD test because Athena is the only laboratory in the U.S. that performs sequencing and deletion analysis for the PKD1/PKD2 genes. Athena employs polymerase chain reaction (PCR) and DNA sequencing to detect sequence variations and quantitative copy number assays to detect duplications and deletions.

I hope you will support this letter of medical necessity for <patient name>. Please feel free to contact me at <phone number> if you have additional questions.

Sincerely,

<Physician Name>, MD

NPI #: <Physician NPI#>

Contact information:

< Address>

<City>**,** <State>, <Zip>

Contact Phone No.: <phone number>

1. Tan, Y et al. Human Mutation. 2009. Vol. 30, No. 2, 264–273. [↑](#footnote-ref-1)
2. Connor, A. et al. American Journal of Transplantation. 2008. 8: 232–237 [↑](#footnote-ref-2)