

How to Craft a Letter of Medical Necessity (LMN)

with Gemini: From CPT Code to a Customized Draft

A step-by-step guide to get a CPT code and a Letter of Medical Necessity draft for clinical and payer review using a structured prompt.

1 Gather Key Information

Collect the critical details Gemini will need to generate the CPT code and draft your letter.

- Procedure name (e.g., Knee Arthroscopy)
- Diagnosis / ICD-10 code
- Patient symptoms & functional impact
- Treatments already tried
- Clinical rationale for the procedure
- Insurance provider (if known)

2 Use a Structured Prompt in Gemini

Paste a clear, detailed query like the template below and fill in your specific information.

3 Review and Customize

Gemini will provide:

- the appropriate CPT code
- a comprehensive, professionally formatted Letter of Medical Necessity

Review the draft for accuracy, add any missing details, and edit as needed for your specific patient and insurance plan. Verify all codes and clinical facts before use.

4 Use This Prompt Template

Copy and paste this into Gemini, replacing the bracketed information with your details.

Prompt:

"I am requesting the CPT code for [Insert Procedure Name, e.g., Knee Arthroscopy]. After identifying the correct code, please draft a comprehensive Letter of Medical Necessity for insurance authorization. Use the following details:

- Diagnosis / ICD-10 Code:** [Insert Diagnosis]
- Patient Symptoms & Functional Impact:** [Insert Symptoms, e.g., severe joint pain, inability to bear weight]
- Treatments Already Tried:** [Insert Prior Treatments, e.g., 6 weeks of physical therapy, NSAIDs]
- Clinical Rationale:** [Insert why this procedure is necessary now]
- Insurance Provider:** [Insert Health Plan Name, if known]

Format the letter professionally with clear sections for Diagnosis, Functional Impact, Prior Treatments, and Clinical Rationale."

5 Key Elements for a Strong Letter

Including these details helps ensure the LMN is complete and meets common insurance requirements.

- CPT & ICD-10 Codes**
The target procedure code paired with the diagnosis code.
- Prior Treatments Tried & Failed**
Insurers look for "step therapy" — proof that lower-cost or less invasive treatments (medications, physical therapy, conservative care) were attempted first.
- Functional Impairment**
Specific details on how the condition affects daily activities, work, or safety.
- Clinical Rationale**
Explicit justification for why the requested procedure is the accepted standard of care and what risks exist if coverage is denied.
- Insurance Provider**
Include the health plan name if known.

6 Example Output from Gemini

Here's a simplified example of what Gemini might provide.

CPT Code: 29881 (Arthroscopy, knee, surgical; with partial meniscectomy)
ICD-10-CM: [verify code from the documented diagnosis]

Letter of Medical Necessity

[Provider Letterhead]
Date: [Insert Date]
To: [Insurance Provider Name]
Re: Letter of Medical Necessity for [Patient Name, DOB (optional)]
Member ID: [Insert if available]

Dear Medical Review Team,

I am writing to request prior authorization for a right knee arthroscopy with partial meniscectomy (CPT 29881) for my patient, [Patient Name]. This procedure is medically necessary based on the following:

Diagnosis	ICD-10-CM: [verify code from the documented diagnosis]
Functional Impact	The patient experiences severe right knee pain, swelling, and mechanical symptoms, including locking and instability, which significantly limit daily activities, work duties, and the ability to bear weight and participate in normal physical activities.
Prior Treatments	The patient has completed 6 weeks of physical therapy, used NSAIDs, activity modification, and bracing without significant or sustained relief of symptoms.
Clinical Rationale	Given the persistent symptoms, failure of conservative treatment, and imaging consistent with a meniscal tear, a right knee arthroscopy with partial meniscectomy is the appropriate next step and aligns with accepted standards of care. Without this procedure, the patient is at risk for continued pain, functional decline, and potential progression of joint damage.

I respectfully request your approval for this medically necessary procedure. Please contact me if additional information is required.

Sincerely,
[Provider Name, Credentials]
[Practice Name]
[Contact Information]

7 Privacy & Compliance Note

Never paste Protected Health Information (PHI) like real patient names, dates of birth, or social security numbers into consumer AI tools. Use placeholder names or generic tags (e.g., [Patient Name]) when generating drafts.

Copy & paste the prompt

A text companion to the Letter of Medical Necessity infographic

Replace the bracketed items with documented facts. Copy the text in the box, paste it into an AI tool approved by your organization, and review the result before use.

PROMPT

I am requesting a CPT code suggestion for [Procedure Name]. After identifying a candidate code, please draft a Letter of Medical Necessity for clinical and payer review.

Use only the documented facts below. Do not invent diagnoses, code descriptors, treatment outcomes, or payer criteria. If information is missing, write 'not documented' and flag it for review.

Procedure: [Insert procedure name]

ICD-10-CM: [verify code from the documented diagnosis]

Patient symptoms and functional impact: [Insert documented details]

Treatments already tried and response: [Insert documented details]

Clinical rationale for the procedure: [Insert documented rationale]

Insurance provider and relevant criteria, if known: [Insert details]

First, list the proposed CPT code and label it 'verify before use.' Then draft the letter with clear sections for Diagnosis, Functional Impact, Prior Treatments, and Clinical Rationale. Explain the requested service using only the facts above.

Finish with a short nurse review checklist of missing details, codes, and payer requirements to verify. Do not present the draft as a coverage determination. Use placeholders for names and identifiers.

Review before submission

Confirm the proposed CPT and ICD-10-CM codes against current references, match every statement to the medical record, and check the payer's requirements. Keep identifiable patient information out of tools your organization has not approved for that use.

Verification references:

CMS ICD-10-CM guidelines | HHS guidance on cloud services and ePHI