Letters of Medical Necessity

From understanding who is making the funding decision to painting the best picture of the beneficiary's need, the complexity of the letter of medical necessity can be minimized by addressing specific issues.

By Sarah Rollman, MSA, JD

Times certainly have changed since I wrote my first letter of medical necessity in 1988. Back then, one paragraph, which was nothing more than the concluding statement that the equipment for which I was seeking funding was medically necessary, was enough to get authorization from the insurance company.

Needless to say, those days are gone. My most recent letter was five pages and analyzed not only why the patient needed the particular mobility system for which we were attempting to get coverage, but also why none of the less costly systems would work. And the letter was accompanied by a three-page physical evaluation and a two-page home evaluation,

Funding sources place a tremendous burden on health care professionals by requiring extensive justification before granting authorization for the purchase of equipment. Since most people are dependent upon insurers to pay for medical expenses, health care professionals must become proficient at writing the requisite letter of medical necessity.

In order to write an effective letter of medical necessity, it is important to understand the primary principles of law relating to insurance coverage. Insurance is a contract between an insurance carrier and a beneficiary, whereby the beneficiary is entitled to reimbursement for medical expenses. In order to get payment, the beneficiary has the burden of proving a covered loss. This means that the beneficiary, or his provider, must submit a claim to the insurer. The burden then shifts to the insurer to either pay or deny the claim. To deny a claim, an insurer must prove loss is clearly and unambiguously excluded from coverage under the written terms of the insurance policy. In other words, if a medical insurance policy does not state that a medical expense is excluded from coverage, the expense is probably reimbursable.

The second step to writing an effective letter is understanding the meaning of medical necessity. Most insurance contracts specifically state that just because a service or supply is ordered by a doctor does not mean that it is medically necessary.

Then what is medical necessity? This question can be answered only by looking at each individual insurance policy. Each insurer defines the term in a different manner and the same insurer might use different definitions of medical necessity in different policies.

The insurer's definition of medical necessity is usually contained in the insurance benefits booklet, which is often called the summary plan description. Upon request insurers will often fax the relevant policy definitions to you. If you cannot get the definitions and time is of the essence, your only choice is to write a thorough letter. However, if the claim is denied, it behooves you to take the time to get a copy of the benefits booklet before filing any appeals.

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Your goal must be to get approval for the equipment on the first go around. Although you will have an opportunity to appeal any denials, only a small percentage of denials are overturned.

Your letter must be geared to your audience. Do not use terms, acronyms and other abbreviated methods of describing a beneficiary's condition or a piece of equipment. Paint a picture of the beneficiary and create an understanding of the equipment for which you are seeking approval using only those terms that can be understood by an ordinary person who has never worked in health care and who has never seen or heard of the equipment.

I start with an outline when writing letters of medical necessity. My opening sentence states who I am and what I want, that being authorization for a particular piece of equipment. I then explain the beneficiary's condition. I state the diagnosis or nature of the injury. Then I discuss the impact on the person's life, noting both the limi-

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tations and the abilities of thebeneficiary without adaptive equipment. Since insurers like to know improvements in functional abilities, I explain how each limitation causes a decrease in the beneficiary's level of function so that I can readily demonstrate how the equipment for which I am seeking approval will result in increased function.

Your letter is the only opportunity fomon-health care professionals in your audience to understand the beneficiary's need. It might seem like you are stating the obvious, but if the insurer has never seen a person with quadriplegia, it may not occur to the insurer that a person with no movement below the neck cannot scratch an itch, wipe a runny nose or get something to eat.

My next step is to describe the equipment. I explain how it works and of all the ways in which the equipment will improve the beneficiary's function. I explain why the beneficiary cannot use possible alternatives and why the alternative will not improve function to the level possible with the equipment I recommend. Additionally, I make it known if the alternative is contraindicated or poses any risk to the beneficiary. Finally, because insurers want to save money, I explain how the equipment can replace other expenses, such as attendant care, or is otherwise cost-effective. This is critical when writing letters of medical necessity for equipment that is new and/or more expensive than other accepted alternatives.

Your letter is the only opportunity for non-health care professionals in your audience to understand the beneficiary's need.

I then address the insurer's definition of medical necessity. I don't go overboard here because, if I wrote a good letter thus far, this section is repetitious. I simply state that the policy requires that the equipment meet certain criteria in order to be considered medically necessary. I then provide a one sentence explanation of how each criteria is met.

For example, one of the criteria may be that the equipment must be ordered by a physician. In response, I will write that "in order to be considered medically necessary, the equipment must be ordered by a physician. I have enclosed a prescription from the treating physician."

I work with the same insurers over and over again; I know particular biases held by some of them. For example, some insurers believe that all persons with high level spinal cord injuries should use the same equipment as Christopher Reeve. In such cases, I will provide a non-confrontational explanation of the reason different equipment is more appropriate or the reason the equipment used by Reeve is contraindicated.

In closing, I make the beneficiary a real person facing a difficult adversity. I want the insurer to understand that he or she would not want to trade places with the beneficiary, but that the insurer can improve the beneficiary's life by agreeing to pay for the equipment.

If the insurer denies authorization, the next step is an appeal. However, the time limit for filing an appeal is limited. If you do not intend

to prepare the appeal on the, beneficiary's behalf, you should immediately contact the beneficiary so that he or she can exercise the rights available under the policy.

If you intend to tile the appeal, you should begin gathering information immediately. You are entitled to an explanation of the specific reasons for the denial, specific reference to pertinent policy provisions on which the denials are based, a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and appropriate information as to the steps to be taken to appeal the denial. If you do not get all of this in the denial letter, ask for it. Additionally, if you have not yet obtained a copy of the benefits booklet, now is the time.

Your appeal must focus on the reasons for the denial. Most denials fall into three categories. The denial may be based on a disagreement between physicians as to what is medically necessary. The denial may be based on an express policy exclusion, such as medical necessity. Or the denial may be based on what I call an "implied' exclusion to coverage. That is, those denials that occur where the policy neither specifically provides for nor specifically excludes coverage for a piece of equipment. In such a case, so long as the equipment can be fit into a general category of coverage, such as the durable medical equipment definition, payment should be made.

Just because a condition existed before the effective date of coverage does not make the condition pre-existing.

Denials based upon disagreements between physicians are the most difficult. In such cases, your goal is to counter each point made by the insurer's physician by providing medical evidence to the contrary so that you can sway the reviewer to your position. You may also want to get a second opinion.

If the denial is based on a policy exclusion, your **goal** is to demonstrate that the equipment falls outside the express language of the exclusion. For example, some insurance policies exclude coverage for pre-existing conditions. However, just because a condition existed before the effective date of coverage does not make the condition pre-existing. Look at the policy's definition of a pre-existing condition. If a pre-existing condition is defined as an illness or injury for which the beneficiary had treatment in the three months before the effective date of coverage, and the beneficiary had the condition but never received any treatment, the condition is not pre-existing.

In evaluating whether a piece of equipment is excluded from coverage, the insurer is not entitled to impose new and additional criteria not contained in the policy. In the case of equipment, the additional criteria I often see imposed is that the equipment is not the least costly alternative. When this occurs, your job is to demonstrate either that the insured cannot use the alternative or that comparing the equipment you

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ommended and the alternative suggested by the insurer is like comparing apples and oranges.

If the denial is based upon an implied exclusion, the goal of the appeal is to find a coverage provision in the policy under which the equipment would fall and to demonstrate that the policy contains no relevant exclusion.

Three other issues arise with appeals. Certain insurers require that you submit a letter from the insured authorizing you to file the appeal on his or her behalf. Secondly, if the insured has any thought of filing a lawsuit to obtain benefits, you must submit any evidence you would like a court to consider with your appeal. If you do not include the report of an expert with your appeal, you may be prevented from introducing expert testimony in any subsequent lawsuit. Finally, if your appeal is late, the insurer does not have to entertain the appeal and you will not be permitted to file a lawsuit to recover benefits.

Letters of medical necessity have certainly grown to be a nemesis for the health care professional. However, so long as the insurance system in our country allows the insurer to keep the money in its pocket until the beneficiary can pry it out, we have no choice but to become proficient in meeting the insurer's requirements.

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