Medical Necessity Letters: A Summary of Best Practices

Medical necessity letters "can be an **essential tool in patients' dealings with insurers, empowering patients to preempt or reverse insurance denials** by reinforcing the basis of case-specific clinical decisions and establishing the clinician's assessment of the treatment as 'medically necessary.'"[1]

Clinicians determine medically necessary care:

- …based on generally accepted standards set by not-for-profit professional societies and aimed at the appropriate clinical goal of recovery.
- Contrarily, insurers may apply their proprietary standards to limit "medically necessary care" to crisis stabilization.
- Federal health insurance regulations do not provide clear guidance as to the standards of required care and coverage for mental health and substance use disorder care.

Medical necessity letter elements:

- Clinician training and practice
- Clinician experience with patient
- Generally accepted standards applied
- Medically-necessary care
- If appropriate, reference to insurer denials, potential risks/danger of delayed/denied care

As such, the goals of a medical necessity letter are:

- For a clinician to document their point-of-care decision-making either in response to or in anticipation of a health insurer's denial (or delay) in the coverage of a patient's care.
- Reference any potential conflict between the clinician's "generally accepted standards" and the insurer's view of "medical necessity."

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Clinical Occasions	Examples	Best Practices
Change in level of care	Transition to/from: • intensive outpatient (IOP), • partial hospitalization (PHP), • residential care, • in-patient care	• Medical necessity letter provided by referring clinician, as part of "hand-off" of patient to referred clinician • Letter supports referred clinician in securing necessary prior authorization • Letter anticipates potential insurer "input" to instead try lower level of care (e.g., "step therapy," "fail first")
Medication change to Rx with known denial risk by insurer	• On insurer's "suggestion" of a different medication inconsistent with clinician's determination	• Letter identifies Rx selection, with references to alternatives considered/rejected, as well as potential risks/dangers to patient
Update in patient status or clinical decision-making	• Notable progress (or reversal) • New or modified treatment plan	• Clinician provides follow-up letter to reflect patient status, with reference to an earlier medical necessity letter
Following notice of denied claim, denied/delayed authorization	• Explanation of Benefits specifies "denied as not medically necessary" • Reversal of previous prior authorization	• Letter may complement clinician contact with insurer regarding care • Letter may support patient self-advocacy with insurer (as supported by Cover My Mental Health
Following denial for treatment deemed "experimental"	• Insurers may deny as experimental a treatment accepted by mainstream medical community	• Include reference of peer-reviewed publications and basis of evidence for the clinical plan

[1] "Providing a Routine Medical Necessity Letter to Improve Access to Care for Our Patients", Journal of Psychiatric Practice, July 2021; Feldman, et al