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.

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**

- 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.

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 • 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	• Explanation of Benefits specifies "denied as not medically necessary"	• Letter may support patient's claim filing and self-advocacy with insurer
Prior authorization	• At time of prior authorization • Reversal of prior authorization	• Letter may complement clinician contact with insurer regarding care • Letter may support patient's claim filing and self-advocacy with insurer
Higher "dosage" of therapy indicated	• Insurer "inquiry" regarding appointment frequency	• Letter documents medically-necessary frequency of clinical appointments
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