

Considerations for Composing a Letter of Medical Necessity

[Date]

[Payer Name]

ATTN: [Contact Title/Medical Director] [Contact Name (if available)]

[Payor Address] [City, State ZIP]

Re: Letter of Medical Necessity for VNS Therapy System

Patient: [Patient First and Last Name]

Date of Birth: [MM/DD/YYYY]

Subscriber ID Number: [Insurance ID Number]

Subscriber Group Number: [Insurance Group Number]

Case ID Number: [Case ID Number]

Dates of Service: [Dates]

Dear [Contact Name/Medical Director]:

I am writing on behalf of my patient, [Patient First and Last Name], to [request prior authorization of / document medical necessity for] my patient to receive vagus nerve stimulation (VNS) therapy through the implantation of the VNS Therapy System. This letter provides information about the patient's medical history and diagnosis, and a summary of the treatment plan.

Patient's clinical history

[Patient Name] is [a/an] [age]-year-old [male/female] patient who has been diagnosed with [condition] as of [date]. [He/She] has been in my care since [date], having been referred to me by [Referring Physician Name] for [reason].

[Brief summary of rationale for treatment with VNS Therapy System. This includes a brief description of the patient's diagnosis, including the ICD-10-CM code, the severity of the patient's condition, prior treatments, the duration of each, responses to those treatments, the rationale for discontinuation, as well as other factors (eg, underlying health issues, age) that have affected your treatment selection.]

Treatment plan

In July 1997, the US Food and Drug Administration approved the VNS Therapy System as an adjunctive therapy that may reduce the frequency of seizures and improve quality of life.

[Include plan of treatment (dosage, length of treatment) and clinical practice guidelines that support the use of the VNS Therapy System. Consider mentioning experts in the field who also support the treatment.]

Summary

Based on the above facts, I believe the VNS Therapy System is indicated and medically necessary for this patient.

If you have any further questions about this matter, please contact me at [Physician Phone Number] or via email at [Physician Email]. Thank you for your time and consideration.

[Physician Name and Credentials]

Enclosures

[List enclosures, which may include prescribing information, clinical notes/medical records, diagnostic test results, relevant peer-reviewed articles, FDA approval letter, scans showing progressive disease, pathology]