**Appendix A: Template for a Medical Necessity Letter[[1]](#footnote-1)**

Date

Member: [patient]

Member DOB:

To Whom It May Concern:

This letter describes my clinical assessment and the medically necessary treatment for *[patient]*. I have been treating *[patient]* since approximately *[date]*.

[**Provider credentials and practice**] – include a brief summary of your training, medical or other professional school, residency, fellowship and internship training, hospital affiliations, years in practice, peer-reviewed publications in the area in question, relevant specialties relevant to the specific patient, and any other description of your qualifications that inform your professional judgment. The information included here will establish your qualifications to make the clinical determination to be described below.

[**Substantiated clinical assessment**] – include a brief summary of your diagnosis/assessment, focusing on the particulars relevant to the medically necessary treatment that you have determined is appropriate, including:

* Related observations that informed your determination of the treatment plan.
* Peer-reviewed standards and medical treatment guidelines that informed your judgment.
  + For example, you might include the following statements and associated citations: In all areas of medicine, there is no single source of generally accepted standards of care. Rather, generally accepted standards of care are derived from multiple sources such as practice guidelines from professional organizations, guidelines and materials distributed by government agencies, and evidence-based peer-reviewed studies in academic journals.[[2]](#endnote-1)
  + To the extent that this patient’s needs vary from or are atypical vis-à-vis standards and guidelines, it would be helpful to include relevant commentary.
* Considerations related to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the “Federal Parity Act”).[[3]](#endnote-2)
  + Since Congress passed the Federal Parity Act, there has been increasing awareness of its mandate that health insurers must provide substantially equivalent access to care for mental and substance use disorders compared with physical health care.
  + The Final Rules under the Federal Parity Act, issued in 2013 and effective in 2014, expressly forbids insurers from impeding access to medically necessary and contractually obligated mental health services.
  + Some states have also passed laws reinforcing the federal legislation.[[4]](#footnote-2) The 2020 Consolidated Appropriations Act required insurance entities, in effect, to make public their own compliance with the requirements of the Federal Parity Act.
* Considerations related to generally accepted standards of clinical practice as recognized by the behavioral health and psychiatric medical community; include any/all relevant statements from the selections below; these references may also be included in the **course of treatment** section below.
  + Behavioral health experts and leading medical specialty groups such as the American Medical Association, the American Psychiatric Association, and the National Council for Mental Wellbeing,[[5]](#footnote-3) among others, have coalesced around eight principles of effective treatment that reflect generally accepted standards of care.[[6]](#endnote-3) [[7]](#endnote-4)
  + Consistent with these generally accepted standards of effective treatment, my treatment plan is based on a multidimensional assessment that accounts for a wide variety of information about *[patient]*;[[8]](#endnote-5) [[9]](#endnote-6) [[10]](#endnote-7) [[11]](#endnote-8) considers treatment of underlying conditions (e.g., early adversity, trauma, chronicity) and is not limited to alleviation of current symptoms;[[12]](#endnote-9) [[13]](#endnote-10) considers treatment of co-occurring behavioral health disorders and/or medical conditions relevant to a determination as to level and type of care;[[14]](#endnote-11) [[15]](#endnote-12) [[16]](#endnote-13) places *[patient]* in the least intensive and restrictive level of care that is both safe and effective;[[17]](#endnote-14) [[18]](#endnote-15) [[19]](#endnote-16) errs on the side of caution in determining level of care;[[20]](#endnote-17) and includes services needed to improve functioning, maintain day-to-day functioning, and to prevent deterioration.[[21]](#endnote-18) [[22]](#endnote-19) [[23]](#endnote-20)
  + The appropriate level of care for *[patient]* reflects my professional assessment for its treatment efficacy, patient safety, and overall management of their medical needs.
  + My treatment decision regarding the level of care reflects appropriate medical caution after having evaluated *[patient’s]* individual requirements.
  + My determination of the treatment duration is based on *[patient’s]* individual needs.
  + My treatment plan reflects particular care for the unique needs of [children/adolescents] that may be different from those of adults.
  + My determination as to the medically appropriate level of care reflects an overall assessment of the patient, based on my [days/weeks/months/years] of observation.
  + My determination of the medically appropriate level of care is consistent with that recommended using the LOCUS (or ASAM or other professional society criteria for determining level of care).
* **In this medical necessity letter, it is neither necessary nor appropriate to:**

1. speculate on the probability of success with any course of treatment,
2. explore any “what ifs” regarding the potential evolution of the treatment,
3. assess whether the insurance policy will cover the treatment. Your clinical assessment is sufficient.

[**Course of treatment**] – description of the course of treatment that you have determined to be medically necessary, including:

* Summary rationale for your medical decision-making.
* When possible, link your recommendation for medically necessary treatment to a professional society multidimensional assessment instrument, such as the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS)[[24]](#endnote-21) or the Child and Adolescent Level of Care Utilization System (CALOCUS)[[25]](#endnote-22) developed by the American Association of Community Psychiatrists or the American Society of Addiction Medicine (ASAM) criteria.[[26]](#endnote-23)
* Also include reference to relevant elements of effective treatment that reflect generally accepted standards of care [see suggestions in the **substantiated clinical assessment** section above].
* Be sure to use the words “determined to be medically necessary”; leave no doubt that “medically necessary” is the standard for your treatment decision.
* You may wish to include the **Plan’s definition of “medical necessity.”** Many plans require medical necessity to be determined under “generally accepted standards of care.” Your patient can obtain this information by reviewing their full Policy (sometimes referred to as the *Subscriber Certificate and Riders* or *Certificate of Coverage*).
* Identify (a) specific harms that could occur, (b) avoidable risks that could be mitigated, and/or (c) clinical gains that could be lost absent your planned course of treatment.
* This letter is neither a recommendation for approval nor the persuasive presentation of evidence for evaluation by others. Rather, it introduces you and your expertise, summarizes your relationship with and assessment of the patient, and your (by now, obviously qualified) determination.

Should you have any questions, please do not hesitate to contact me.

Sincerely,

[signature]

1. Adapted with permission from Feldman, J., DeBofsky, M., Plakun, E. M., & Potts, C. (2021). Providing a Routine Medical Necessity Letter to Improve Access to Care for Our Patients. *Journal of Psychiatric Practice*, *27*(4), 288–295. <https://doi.org/10.1097/PRA.0000000000000563> [↑](#footnote-ref-1)
2. Some sources of generally accepted standards include:

   American Association for Community Psychiatrists Level of Care Utilization System (LOCUS); American Association for Community Psychiatrists Child and Adolescent Level of Care Utilization System (CALOCUS); American Society of Addiction Medicine (ASAM) Criteria; Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers; Medicare benefit policy manual (CMS Publication No. 100-02); American Psychiatric Association Clinical Practice Guidelines; Diagnostic and Statistical Manual of Mental Disorders, 5th ed. [↑](#endnote-ref-1)
3. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68239 (Nov. 13, 2013). [↑](#endnote-ref-2)
4. You may elect to include a statement regarding any applicable laws pertaining to the state where the patient’s insurance policy was written. ParityTrack, which partners with the Kennedy Forum, among other groups, is a helpful resource: <https://www.paritytrack.org/reports/> [↑](#footnote-ref-2)
5. On May 6, 2021, The National Council for Behavioral Health changed its name to the National Council for Mental Wellbeing  [↑](#footnote-ref-3)
6. *Wit v. United Behavioral Health*. Brief amicus curiae of American Psychiatric Association, American Medical Association, California Medical Association, Southern California Psychiatric Society, Northern California Psychiatric Society, Orange County Psychiatric Society, Central California Psychiatric Society and San Diego Psychiatric Society. 5 May 2021. https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/amicus-briefs/amicus-2021-Wit-v-United-Behavioral-Health-Nos-20-17363-20-17364-21-15193021-15194.pdf. [↑](#endnote-ref-3)
7. The National Council for Behavioral Health. (2019). *Generally Accepted Standards of Care for Behavioral Health* [Position Statement]. https://www.thenationalcouncil.org/wp-content/uploads/2022/02/MDI-Wit-v-UBH-Position-Statement.pdf [↑](#endnote-ref-4)
8. American Association for Community Psychiatry: LOCUS 20 (Level of Care Utilization System), 2016 Available at: https://sites.google.com/view/aacp123/resources/locus [↑](#endnote-ref-5)
9. American Association for Community Psychiatry: CALOCUS 20 (Child and Adolescent Level of Care Utilization System), 2019 Available at: https://sites.google.com/view/aacp123/resources/locus [↑](#endnote-ref-6)
10. Mee-Lee, D., & Shulman, G. (2014). The ASAM criteria and matching patients to treatment. *The ASAM Principles of Addiction Medicine. 5th ed. China: Wolters Kluwer Health*. [↑](#endnote-ref-7)
11. American Psychiatric Association. (2020). *Level of Care Criteria for Acute Psychiatric Treatment* [Position Statement]. https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Continuing-Care-Criteria.pdf [↑](#endnote-ref-8)
12. SAMHSA. (2012). *SAMHSA’s Working Definition of Recovery: 10 Guiding Principles of Recovery* [Brochure]. https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf [↑](#endnote-ref-9)
13. American Psychiatric Association. (2018). *Use of the Principles of Recovery* [Position Statement]. https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Use-of-the-Principles-of-Recovery.pdf [↑](#endnote-ref-10)
14. Druss, B.G. & Reisinger-Walker, E. (2011). *Mental disorders and medical comorbidity* [Research Synthesis Policy Brief No. 21]. Robert Wood Johnson Foundation, Princeton. http://www.rwjf.org/files/research/ 71883.mentalhealth.report.pdf [↑](#endnote-ref-11)
15. Dennis, M. & Scott, C.K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice, 4*, 45-55. doi:10.1151/ascp074145 [↑](#endnote-ref-12)
16. LOCUS, *supra* note 5. [↑](#endnote-ref-13)
17. Plakun, E.M. (2019). Psychotherapy and advocacy: Four freedoms as fundamental patient rights. *Journal of Psychiatric Practice,* *25*(2), 128-131. doi:10.1097/PRA.0000000000000366 [↑](#endnote-ref-14)
18. ASAM, *supra* note 7. [↑](#endnote-ref-15)
19. Lazar, S.G., Bendat, M., Gabbard, G., Levy, K., McWilliams, N., Plakun, E.M., Shedler, J., & Yeomans, F. (2018). Clinical necessity guidelines for psychotherapy, insurance medical necessity and utilization review protocols, and mental health parity. *Journal of Psychiatric Practice*, *24*(3), 179-193. doi:10.1097/PRA.0000000000000309 [↑](#endnote-ref-16)
20. LOCUS, *supra* note 5. [↑](#endnote-ref-17)
21. U.S. Centers for Medicare & Medicaid Services. (Revised 12/31/20). Medicare benefit policy manual chapter 6 - hospital services covered under Part B (CMS Publication No. 100-02). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf [↑](#endnote-ref-18)
22. SAMHSA, *supra* note 9. [↑](#endnote-ref-19)
23. LOCUS, *supra* note 5. [↑](#endnote-ref-20)
24. LOCUS, *supra* note 5. [↑](#endnote-ref-21)
25. CALOCUS, *supra* note 6. [↑](#endnote-ref-22)
26. ASAM, *supra* note 7. [↑](#endnote-ref-23)