**Appendix B: Sample Medical Necessity Letter – Residential**

Date

Member: John Doe

Member DOB: [insert]

To Whom It May Concern:

This letter describes my clinical assessment and the medically necessary treatment for Mr. John Doe. I have been treating Mr. Doe since approximately [insert date].

I am a [insert professional guild] and have been in practice for over [insert] years. I was educated at [insert name of university, medical school, etc.], interned at the [as applicable, insert name of internship program/hospital, etc.], and completed a [insert] year fellowship at [as applicable, insert name of fellowship, residency training program, etc.] where I am now employed as a staff [insert professional guild]. I specialize in working with adult patients, like Mr. Doe, who suffer from complex psychiatric conditions that contribute to treatment resistance. I have authored several publications pertaining to these issues.[[1]](#footnote-1)

Mr. Doe has a history of early adversity and trauma and currently suffers from diagnostically complex and treatment resistant behavioral health conditions. He is diagnosed with major depressive disorder, recurrent, severe with psychotic symptoms (F33.3), alcohol use disorder, moderate (F10.20), generalized anxiety disorder (F41.1), and borderline personality disorder (F60.3). His symptoms cause clinically significant distress and impairment in his social, occupational, family role, recreational, and self-care functioning as evidenced by recent job loss, interpersonal conflict, family discord, difficulty performing at expected levels in work and parenting, social withdrawal, and problems with hygiene.

Over the past several years, Mr. Doe has cycled through intensive outpatient, residential, and inpatient hospitalization programs with failed attempts to sustain functioning within a lower level of care. Given the severity of his current symptomatology, functional impairments, disruptions in his support systems and recovery environment, and difficulty forming and sustaining trusting treatment alliances, Mr. Doe requires consistent immersion in a treatment environment with 24-hour nursing and other therapeutic supports. Individuals who have experienced early adversity, such as Mr. Doe, often require real-time psychosocial interventions within a therapeutic milieu to feel safe enough to learn from the psychotherapy and other treatment offerings.[[2]](#endnote-1)

The residential treatment program at the [insert Name of the Treatment Center] is a national referral center for treatment resistant patients, such as Mr. Doe.  Most of our patients present with treatment refractory disorders that have failed to respond adequately to past treatment efforts. Our treatment is designed to address problems underlying recurrent acute symptoms with the goal of interrupting cycles of ineffective treatments and poor adjustment in the community. This program includes 24-hour nursing on site, a psychosocial therapeutic milieu with skill building and multiple group therapies, substance use and medical services, family work, intensive individual psychotherapy, psychopharmacologic meetings with a staff psychiatrist, and social work meetings to promote independent living and life skills. We are collaboratively working with Mr. Doe to assess his ability to engage in treatment safely and effectively at a lower level of care. However, Mr. Doe currently requires more structure and support than can be provided through even the most rigorous outpatient program.

As you are likely aware, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the “Federal Parity Act”) is an insurance nondiscrimination law designed to protect patients who seek treatment for mental health and substance use disorders. [Insert Insurance Company] and their contracted third-party plan administrators are bound by federal and state antidiscrimination laws that protect patients with mental health and substance use conditions and provide for their access to needed medical 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 including access to intermediate levels of care such as residential treatment.[[3]](#footnote-2) [[4]](#footnote-3)

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.[[5]](#endnote-2) 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,[[6]](#footnote-4) among others, have coalesced around **eight principles of effective treatment** that reflect generally accepted standards of care.[[7]](#endnote-3) [[8]](#endnote-4) These standards are consistent with non-profit professional sources of accepted standards, such as the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) and the American Society for Addiction Medicine Treatment Criteria for Addictive, Substance Related and Co-Occurring Conditions (ASAM Criteria) that evaluate medical necessity for treatment throughout the continuum of care. Following these standards is seen as best medical practice.

My determination as to the medically appropriate level of care reflects an overall assessment of Mr. Doe based on clinical observation, a review of his medical records, and use of the LOCUS criteria for determining level of care. The LOCUS is a nationally used third-party guide developed by the American Association of Community Psychiatrists that assesses service needs over six dimensions and six defined levels of resource intensity. Based on the following LOCUS scores, Mr. Doe meets criteria for **Level Five – Medically Monitored Residential Services**, which he is receiving at the[insert Name of the Treatment Center]. Here are his full scores. Please note that I am certified by the American Association of Community Psychiatrists (AACP) to score the LOCUS and generated these scores via an electronic scoring algorithm [LOCUS Version 20] licensed by Deerfield Solutions, LLC., on behalf of the AACP.[[9]](#footnote-5)

Dimension I: Risk of Harm - Level [insert] – [insert] Risk of Harm: Meets criterion [insert]

Dimension Il: Functional Status - Level [insert] – [insert] Impairment: Meets criterion [insert]

Dimension III: Medical, Addictive, and Psychiatric Co-Morbidity - Level [insert] – [insert] Co-morbidity: Meets criterion [insert]

Dimension IV: Recovery Environment A) Level of Stress - Level [insert] – [insert] Stressful Environment: Meets criterion [insert]

Dimension IV: Recovery Environment B) Level of Support - Level [insert] – [insert] Support in Environment: Meets criterion [insert]

Dimension V: Treatment and Recovery History - Level [insert] – [insert] Response to Treatment and Recovery Management: Meets criterion [insert]

Dimension VI: Engagement - Level [insert] – [insert] Engagement and Recovery: Meets criterion [insert]

As demonstrated, there are good clinical reasons to believe that treatment at a residential level of care is medically necessary and consistent with generally accepted standards of effective treatment. In line with generally accepted standards of effective treatment, my treatment plan is based on a **multidimensional assessment** that accounts for a wide variety of information about Mr. Doe;[[10]](#endnote-5) [[11]](#endnote-6) [[12]](#endnote-7) [[13]](#endnote-8) includes treatment of **co-occurring disorders** including mental health, substance use, and medical;[[14]](#endnote-9) [[15]](#endnote-10) [[16]](#endnote-11) includes treatment of **underlying conditions** (e.g., early adversity, trauma, chronicity) **and is not limited to alleviation of current symptoms**;[[17]](#endnote-12) [[18]](#endnote-13) considers Mr. Doe’s **individual needs without arbitrary limits on the duration of such treatment**;[[19]](#endnote-14) [[20]](#endnote-15) [[21]](#endnote-16) [[22]](#endnote-17) includes services needed to **improve functioning, maintain day-to-day functioning, and to prevent deterioration**;[[23]](#endnote-18) [[24]](#endnote-19) [[25]](#endnote-20) places Mr. Doe in the **least intensive and restrictive level of care that is both safe and effective**;[[26]](#endnote-21) [[27]](#endnote-22) [[28]](#endnote-23) and **errs on the side of caution** in determining level of care.[[29]](#endnote-24)

The appropriate level of care for Mr. Doe reflects my professional assessment for its treatment efficacy, patient safety, and overall management of his behavioral health needs. It is my professional opinion that Mr. Doe’s condition would deteriorate and potentially require re-hospitalization if his current treatment services were prematurely withdrawn. I trust you are committed to upholding your legal and ethical responsibility as Mr. Doe’s fiduciary. I am sure Mr. Doe will expect you to honor the terms of his Plan.

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

Sincerely,

[signature]

1. Cite publications (or other relevant qualifications), as appropriate [↑](#footnote-ref-1)
2. Fonagy, P., Luyten, P., & Allison, E. (2015). Epistemic petrification and the restoration of epistemic trust: A new conceptualization of borderline personality disorder and its psychosocial treatment. *Journal of Personality Disorders,* 29, 575-609. doi.org/10.1521/pedi.2015.29.5.575. [↑](#endnote-ref-1)
3. 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)
4. As applicable, 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*). [↑](#footnote-ref-3)
5. 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 [↑](#endnote-ref-2)
6. On May 6, 2021, The National Council for Behavioral Health changed its name to the National Council for Mental Wellbeing  [↑](#footnote-ref-4)
7. *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)
8. 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)
9. If you are interested in pursuing LOCUS training, see <https://deerfieldsolutions.com/training>; For electronic LOCUS scoring options, see <https://deerfieldsolutions.com/licensing> [↑](#footnote-ref-5)
10. 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)
11. 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)
12. 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)
13. 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)
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-9)
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-10)
16. LOCUS, *supra* note 5. [↑](#endnote-ref-11)
17. 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-12)
18. 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-13)
19. 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-14)
20. 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-15)
21. APA, *supra* note 8. [↑](#endnote-ref-16)
22. APA, *supra* note 13. [↑](#endnote-ref-17)
23. CMS, *supra* note 14. [↑](#endnote-ref-18)
24. SAMHSA, *supra* note 12. [↑](#endnote-ref-19)
25. LOCUS, *supra* note 5. [↑](#endnote-ref-20)
26. 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-21)
27. ASAM, *supra* note 7. [↑](#endnote-ref-22)
28. Lazar, *supra* note 15. [↑](#endnote-ref-23)
29. LOCUS, *supra* note 5. [↑](#endnote-ref-24)