LETTER OF MEDICAL NECESSITY CHECKLIST

Checklist for Writing a Letter of Medical Necessity

A detailed letter of medical necessity (LMN) contains:

- ☐ Patient information (name, date of birth, address, contact information, Insurance Information)
- ☐ Provider information (name, credentials, clinic/hospital name, contact information)
- ☐ Date of the letter
- ☐ Recipient information (name of insurance company, address, specific department/contact information)
- ☐ Statement of medical necessity (explanation of diagnosis that requires the treatment, procedure, equipment, medication)
- ☐ Medical history (summary of medical condition, diagnosis/onset, co-morbidities)
- ☐ Description of medical treatment or service requested
- ☐ Supporting evidence (medical reports, test results)
- ☐ Clinical rationale (benefits and expected outcomes, e.g., improve patient's health, function, quality of life)
- ☐ Alternative treatment (What's been done and outcomes or why something cannot be done)
- ☐ Duration and frequency
- ☐ Cost information as applicable
- ☐ Conclusion (importance of the request)

Additional pertinent information when requesting specific equipment:

- ☐ Functional and physical assessments including, but not limited to, strength, range of motion, tone, sensation, balance, Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADL's), and functional status
- ☐ Documentation of other devices considered, and why each was ineffective for the consumer
- ☐ Documentation of trialed device(s) and outcomes of the trial(s)
- ☐ Justification for the model of device being recommended as well as each option and accessory required by the consumer
- ☐ Evidence that the consumer demonstrated the ability to safely use the device independently or with appropriate assistance
- ☐ Outline of the prescribed treatment recommendations
- ☐ Any applicable research or documentation to support intended outcomes
- ☐ Possible adverse outcomes that may occur without the requested items (examples: increased number of hospitalizations or ER visits, loss of independence)

Individualized Considerations for Equipment and Treatment

Cough Assist:

- ☐ Include diagnostic testing (if able to perform/support the argument)
- ☐ MIP/MEP and peak cough flow if reduced
- ☐ Diagnosis (SMA, must be stated) and degree of hypotonia
- ☐ If physical therapist or evaluator has noted reduced CHOP INTEND scores, include these as indications for global hypotonia
- ☐ Basic information on how impaired airway clearance affects the health of the individual with SMA and increases the risk for pneumonia and requiring emergency care/hospitalization, and increased healthcare utilization
- ☐ If clinical information is available on the following, include:
    - ☐ Number of respiratory illnesses needing antibiotics with urgent care/ER visits
    - ☐ Number of hospitalizations for respiratory illness
    - ☐ If airway clearance vest was used inpatient, state that
    - ☐ If the patient had a significant improvement in oxygen saturation with decreased need for supplemental oxygen requirement and decreased work of breathing that is documented after the initiation of airway clearance, state that as well in the LMN

Airway Clearance Vest:

- ☐ Include diagnostic testing (if old enough/able to perform/support the argument)
- ☐ MIP/MEP and peak cough flow if reduced
- ☐ Diagnosis (SMA, must be stated) and degree of hypotonia
- ☐ If physical therapist or evaluator has noted reduced CHOP INTEND scores, include these as evidence for diffuse hypotonia
- ☐ Basic information on how impaired airway clearance affects the health of the child and increases the risk for pneumonia and respiratory failure
- ☐ If clinical information is available on the following, include:
    - ☐ Number of respiratory illnesses needing antibiotics with urgent care/ER visits
    - ☐ Number hospitalizations for respiratory illness
    - ☐ If airway clearance vest was used inpatient, state that
- ☐ If the patient had a significant improvement in oxygen saturation with decreased need for supplemental oxygen requirement and decreased work of breathing that is documented after the initiation of airway clearance, state that as well in the LMN
- ☐ Identify why other devices like chest physiotherapy (CPT) with hand clapping and handheld oscillatory devices (PEP/Acapella/Flutter/Aerobika) are not appropriate or will not be successful (case by case):
    - ☐ PEP/Acapella/Flutter/Aerobika:
        - ☐ patients must be an appropriate age and have adequate respiratory muscle strength to follow directions to use the device and generate the flows necessary to perform these maneuvers.
        - ☐ These are patient driven devices
    - ☐ Chest Physiotherapy (CPT):
        - ☐ Multiple care providers/inconsistent care
        - ☐ Difficulty positioning the patient for CPT
        - ☐ Scoliosis
        - ☐ Weight/size (too heavy for providers)
        - ☐ Concern for low bone density and fractures with CPT

Ventilator and BIPAP Devices:

Note: Bilevel positive airway pressure (BIPAP) devices are approved for in home use by children and adults with a minimum weight of 30 kg. BIPAP devices are used non-invasively with a mask on the face.

- ☐ Ventilators are approved for in home use in children over 5 kg and can be used non-invasively with a mask on the face or with tracheostomy tube
- ☐ To qualify for BIPAP device, must include diagnoses of alveolar hypoventilation secondary to neuromuscular weakness or respiratory failure. Do not use Obstructive Sleep Apnea (OSA) as only diagnosis
- ☐ Indicate the ventilation mode must have a backup respiratory rate
    - ☐ Reason is due to neuromuscular weakness and alveolar hypoventilation and causes difficulty triggering inspiratory breaths and increased risk for CO_2 retention and respiratory failure due to low generated flows
- ☐ For Non-invasive ventilatory support in children less than 30kg (66lbs) (requires ventilator)
    - ☐ Include sleep study or lab work that shows respiratory failure/alveolar hypoventilation
    - ☐ Blood gas with elevated pCO_2
    - ☐ Include patient weight. BiPAP machines do not have adequate flow sensors for smaller patients and are not FDA approved for NIV use in individuals less than 66lbs (30kg)

Wheelchair/Stander/Bracing
(Tips for therapist and durable medical equipment company):

- ☐ Document evaluation of the client's systems including both neurologic and orthopedic, their postural assessment, and their level of function
- ☐ State that the patient can't stand or ambulate with any assistive device
- ☐ State that the patient is unable to use a lesser cost manual chair and why
- ☐ State why the patient can't propel a manual wheelchair
- ☐ If advocating for a power wheelchair, document reasons the patient is unable to use a scooter
- ☐ Include that patient is willing to use the recommended complex rehab technology that has been recommended and they can do so safely
- ☐ Discuss how the recommended complex rehab technology will assist with:
    - ☐ Functional activities of daily living
    - ☐ Mobility
    - ☐ Positioning/posture
    - ☐ Independence
- ☐ Other key items to include:
    - ☐ A clinical and medical justification for every aspect of the chair that is recommended
    - ☐ A statement of concurrence with the physician of the prescribing equipment that recommended the equipment as well as his or her signature
- ☐ A statement of financial independence of the PT or OT from the vendor
- ☐ A face-to-face evaluation from the physician and a prescription from the physician
- ☐ Additional documentation will be required if prescribing a power wheelchair
- ☐ Be up-to-date with the CMS guidelines and local and national coverage determination of mobility assistive equipment

Medication/Treatment

- ☐ SMA pathophysiology
- ☐ Description of the recommended treatment
- ☐ Treatment dosing schedule
- ☐ Administration of treatment
- ☐ Clinical trial information
- ☐ Rationale for treatment/failure of alternative treatments
- ☐ Impact on functional status
- ☐ Patient's prognosis without treatment