

Sample Letter of Medical Necessity

Provided to you by Allergan

Note: This is a sample only, letters of medical necessity must be customized for each patient as supported by documentation in the patients medical record(s). Payers vary on their requirement for letters of medical necessity and it may be necessary to submit with copies of medical records.

To: Attention: Medical Director [DATE]
[INSURER NAME]
[Address]
Re: [Patient's Name]
[Group # XXXXX]
[ID # XXXXXXXX]

We are writing on behalf of [PATIENT'S NAME] to obtain certification of insurance coverage, confirmation of benefits, and benefit pre certification for bariatric surgery using a laparoscopic adjustable gastric restrictive procedure (CPT code 43770). The procedure will be performed at [HOSPITAL NAME] by [SURGEON NAME] with a surgical fee of [\$xxxx]. An assistant surgeon will also be required.

We follow the NIH Guidelines for the treatment of morbid obesity (ICD-9 code 278.01). These guidelines, set forth in the NIH consensus conference of 1991, determined that a patient whose body mass index (BMI) exceeds 40 is a potential candidate for surgery. Surgery is also medically indicated for persons with a BMI of 35 or higher when accompanied by a serious co morbidity, or those who are 100lbs or more over their ideal weight. It is indicated for use only in severely obese adults who have failed more conservative weight reduction alternatives.

[PATIENT'S NAME] is a [AGE] year-old [SEX] with a height of [HEIGHT] and a weight of [WEIGHT], giving a BMI of [XX]. The patient has been extremely motivated to lose weight and has considerable knowledge and insight into the various treatment modalities for achieving weight loss including the surgical options of gastric bypass, gastric stapling, and gastric banding. The patient was referred to our program by their primary care physician. [Attach copy of PCP referral or Letter of Recommendation, if available/where appropriate]

[PATIENT'S NAME] has been dieting for the majority of his/her life. [He/She] has a long history of prior weight loss efforts that have been successful in some initial weight loss, but unfortunately, not successful in maintaining any significant weight loss long-term. Some of the more notable efforts include:

Unsupervised

- [provide examples and dates]

Supervised

- [provide examples and dates]

[PATIENT'S NAME]'s morbid obesity is accompanied by the following significant comorbidities: (List any that are documented in the patient medical record) [Diagnosis codes are included for searching in coded records and may not need to be listed in the letter.] (Be sure to describe the severity and effect on daily activities).

- Osteoarthritis of the knees (715.96)
- Osteoarthritis of the spine (721.90)
- Osteoarthritis of the hip (715.15)_etc.
- Sleep Apnea (327.23 – 327.29)
- Hypertension (401.0 – 405.99)
- Diabetes mellitus (250.00 – 250.99)
- Hypercholesterolemia (272.0, 272.1, 272.2)
- Reflux (530.0 - 530.81)
- Heartburn (787.1)
- Stress incontinence (625.6 female, 788.32 male)

[Provide information on family history, psychiatric history, and alcohol or drug abuse history as pertinent to the patient's obesity/or limitation of functioning.]

For example:

Three members of the patient's immediate family, including his/her sister, are morbidly obese. He/She has neither psychiatric history nor alcohol or drug abuse history. This patient has been evaluated by our bariatric team and is found to be an appropriate candidate for this therapy. Surgical intervention has been demonstrated to provide the only effective therapy available for long-term control of morbid obesity; therefore we have elected to use the LAP-BAND® System.

[PATIENT'S NAME] has agreed to this surgery because the LAP-BAND® System procedure is minimally invasive. It is also adjustable, and the procedure is reversible, unlike some other bariatric procedures. It is implanted laparoscopically which reduces wound complications and operating time. It requires less postoperative analgesia and results in a shorter hospital stay (Fisher BL. *Obes Surg.* 2004;14:67-72).

The LAP-BAND® System received FDA approval in June 2001. The FDA has established stringent requirements for the use of this device, which are detailed in the product labeling; both from the standpoint of qualifying surgeons to implant and adjust the device, as well as identifying appropriate patients who may benefit from this therapy. I have undergone detailed training in conformance with the product's labeling and my professional assessment is that this patient meets and/or exceeds all clinical indications for this therapy. Additionally, the LAP-BAND® System was mentioned as 1 of 4 effective surgical options for sustained weight loss by a consensus statement of nationally known bariatric surgeons (Buchwald H. *J Am Coll Surg.* 2005;200:593-604).

Both the American Society for Metabolic and Bariatric Surgery (ASMBS) and the Society of American Gastrointestinal Endoscopic Surgeons (SAGES) have established guidelines for the laparoscopic treatment of morbid obesity. The use of the LAP-BAND® System adheres to these guidelines and this patient meets the indications for surgery and understands its risks and benefits. In addition, our bariatric center is able to provide appropriate, [long-term] [follow up] [supportive] care for this patient. Our practice also institutes a multidisciplinary approach (nutritional, physiotherapy/exercise, and psychosocial) to the disease and to the surgical treatment of morbid obesity. We have strong experience and excellent outcomes with advanced laparoscopic procedures.

The LAP-BAND® System has been demonstrated to be effective in the treatment of morbid obesity. I believe [PATIENT'S NAME] is an ideal candidate for this procedure in that the patient has demonstrated through numerous prior commitments that weight loss—as much as [XX] pounds—was possible, but not sustainable.

Please confirm that this procedure is authorized for reimbursement and that benefits are available for this patient. If you have any questions or concerns, feel free to contact me through our bariatric patient care coordinator, [CONTACT NAME and PHONE].

Sincerely,

[SIGNATURE]