



Considerations for Drafting a Statement of Medical Necessity

This resource is provided as educational support to assist health care professionals and the patients they serve. Healthcare professionals may choose to use these tips to assist in their access to United Therapeutics treatment prescribed. This is not a guide or instructions. United Therapeutics does not guarantee coverage or reimbursement for the United Therapeutics treatment prescribed. The healthcare professional has the responsibility to ensure correct prior authorization policies are followed. Providers must ensure they accurately complete and submit necessary information to insurance companies.

It may be helpful to include a Statement of Medical Necessity (SMN) letter, explaining your rationale and clinical decision making behind the choice of a specific therapy, when submitting a prior authorization to a patient's health insurance.

TIPS FOR DRAFTING AN STATEMENT OF MEDICAL NECESSITY LETTER



1. Understand the Insurer's Prior Authorization Process. Review the patient's plan benefits thoroughly prior to drafting a Statement of Medical Necessity (SMN) letter.



2. Ensure you have submitted all required information. Simple errors on insurance forms, including incorrect codes and failure to obtain or submit necessary documentation may lead to denials. If there was a documentation error correct the form or contact the insurance plan.



3. Identify and meet specific insurer deadlines. Some plans have very short turnaround times, for example 48 hours from denial date.



4. Consider including the following information in the SMN Letter:

- a) Patient Information:
 - Full name
 - Date of birth
 - Insurance ID number
 - Insurance Case ID number or Denial number
- b) Physician Information:
 - Full name
 - National Provider Identification (NPI) number
 - Specialty
- c) An introduction explaining the purpose of the SMN Letter, or the reason for the medical necessity of the prescribed medication.
- d) A summary of the patient's diagnosis and the indication for the United Therapeutics therapy being prescribed. The summary should include diagnosis codes (ICD-10), prior treatments with their duration and response to treatment, and the severity of the patient's condition.
- e) A clinical rationale for the prescribed treatment. The clinical rationale should include the FDA approved indication and any supporting clinical trial data.
- f) If the plan is indicating a preferred formulary treatment, please provide an explanation of why it may not be applicable to your patient.
- g) Additional Documents, including but not limited to:
 - a. Full Prescribing Information
 - b. Diagnostic test results, such as 6-minute walk test
 - c. Letter of Medical Necessity
 - d. Clinical notes and medical records



5. Be sure to maintain accurate records. Make a copy of anything you send, record the time, date and name of any representatives at the insurance company.



Sample Statement of Medical Necessity

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Print letter on the Physician's letterhead

PHYSICIAN LETTERHEAD

[Date]

Attn: [Contact/Medical Director First & Last Name]
[Insurance Company]
[Address]
[City, State, ZIP code]

RE: Letter of Medical Necessity for [Drug Name] and Dosage: [Dose & Frequency]

[Patient First & Last Name]
[Date of Birth]
[Policy Number]
[Claim/Case Number]

Dear [Insert Contact/Medical Director First & Last Name],

I am writing on behalf of my patient [Patient Name], to document the medical necessity for [Drug Name]. [Drug Name], is indicated for the treatment of [Drug Indication], therefore I believe that [Drug Name], is the appropriate treatment for the patient, based on the patient's relevant clinical history provided below.

Brief summary of Patient's Medical History:

[Patient First & Last Name] is [female/male] patient [age], who has been diagnosed with [condition] as of [diagnosis date]. [He/She] has been in my care since [date].

Summary of Patient's History: [Patient's diagnosis, date of diagnosis and any applicable diagnosis codes], [Laboratory results and date], [Brief description of patient's current medical condition], [Patient's previous and current treatments/therapies], [Patient's response to those treatments/therapies], [If the patient has discontinued, include information on lack of response or tolerability]

Rationale for Treatment

Considering the patient's medical history, current medical condition, and the supporting uses of [Drug Name], I believe treatment with [Drug Name] at this time is warranted, appropriate, and medically necessary for this patient.

Please call my office at [telephone number] if you require any additional information or documentation. I look forward to your timely response.

Sincerely,

[Prescriber First & Last Name]

Enclosures: List enclosures such as EOB, denial letter, Prescribing Information, clinical evidence, or lab reports.

Download and include the full prescribing information

