Sample Letter of Medical Necessity for Dynacleft and Nasal Elevator

IMPORTANT NOTE TO PROVIDER:

This letter is a sample provided for information purposes only and represents no statement, promise or guarantee by Southmedic Inc. concerning levels of reimbursement, payment or charges. This letter contains some illustrative examples of possible coding options to assist in supporting insurance claims. Many factors affect payment, not all of which can be anticipated or described in the information contained or provided herein. You should exercise independent clinical judgment when selecting codes and submitting claims to accurately reflect the services rendered to individuals.
This information has been collected from publicly available payer sources and is not intended to increase or maximize reimbursement by any payer. Payer policies may change at any time. Southmedic Inc. strongly recommends that individual payer organizations be consulted to determine current policies and requirements.
For further information contact Southmedc Inc at 1-800-463-7146.
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Re:_____ (insert name of patient), born on _____ (insert date of birth).

To Whom it May Concern:

The above noted patient was born with a _____ (specify unilateral or bilateral cleft lip and/or palate), as per _____ (insert applicable ICD-9 code, for example 749.1 - 749.2), affecting this patient's _____ (insert whichever apply, for example: feeding, breathing, speech, etc). We plan to surgically correct the cleft, with a procedure identified as _____ (describe the procedure), with the corresponding CPT code _____ (insert applicable CPT code, for example CPT 14040-15576, 21080, 40650-40761, 42200-42281). In order to facilitate the surgery and cleft lip approximation, I am bringing the soft tissue and/or skeletal segments on either side of the cleft together before the initial surgical repair.

In order to complete this pre-surgical procedure, additional supplies are required, as follows:

DynaCleft™	$_27 per pouch of 7 (DCX10, unilateral), or
	$ 35 per pouch of 7 (DCX20, bilateral)
Nasal Elevator	$ 48 per pouch of 7 (DCNE-01), or
	$ 192 per pouch of 28 (DCNE-02)

(Add other required supplies, as applicable. Examples are provided below. You will need to insert the unit cost for those used.)

Tegaderm™	$___
DuoDERM®	$___
OpSite™	$___
Mastisol®	$___
Detachol®	$___
Other	$___

These supplies are absolutely necessary for this course of treatment. They should be considered as 'medical supplies' under the patient's medical coverage and should be covered for reimbursement. The CPT code for these supplies is _____ (insert applicable CPT code, eg. 99070). We will not be able to determine how many of the supplies are needed until the end of care, in approximately ___ (insert how many months) months. We will be able to give the exact cost of all supplies used at that time.

Please consider these charges under the patient's medical plan and contact the guardians of this patient directly with your determination.

(Insert guardian's name, address, and phone number)

Sincerely,

(Letter should be signed by the provider)