Writing a Letter of Medical Necessity for Personal Assistance Services (PAS)

A Guide for Health Care Providers

This brochure explains how to write a strong letter of medical necessity to support your patient's request or appeal involving Personal Assistance Services (PAS). This Sample Letter of Medical Necessity includes some sample language that may be useful in explaining your medical opinion.

Step 1: Introduce Yourself and Why You're Writing

Say who you are (primary care physician, specialist, etc.), and how long you have known and treated the patient. Then, give a one-sentence summary of your medical opinion.

Example: "For the reasons explained below, it is my opinion that at least [XX] hours per week of PAS are [or continue to be] medically necessary for Ms. Rodriguez."

Step 2: Describe Your Patient

Briefly list your patient's diagnoses and summarize how these impact their ability to complete activities of daily living (ADLs), such as walking, toilet use and transfer, bathing, personal hygiene, dressing, and eating; as well as instrumental activities of daily living

Legal Definition of Medical Necessity

Under the Community HealthChoices Agreement, a service is medically necessary if it meets any one of the following four standards:

1. The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition, or disability;
2. The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition or disability;
3. The service or benefit will, assist the Participant to achieve or maintain maximum functional capacity in performing daily activities taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; OR
4. The service or benefit will provide the opportunity for a Participant receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of his or her choice.

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(IADLs) including meal prep, housekeeping, transportation, grocery shopping, and medication management.

Example:" Mr. Smith suffers from several chronic health problems, including right side hemiplegia following a stroke, as well as severe arthritis in his spine and both knees. As a result, he experiences chronic pain, weakness, poor balance and unsteady gait that impact his ability to complete activities of daily living in the following ways: . . ."

Step 3: Explain WHY the Requested PAS Hours are Medically Necessary

Using the language of the medical necessity definition in the box on the previous page, explain why the requested PAS hours are necessary. It is not enough to state that PAS is medically necessary, you need to explain WHY the patient needs the amount of PAS they are seeking. Use all relevant parts of the medical necessity definition.

Step 4: Expand on Your Opinion with Helpful Details

- If applicable, attach any medical records that support your opinion about the need for PAS. This may include exam notes, physical therapy evaluations, neurocognitive assessments, ER reports describing falls or other injuries related to lack of adequate care, or other medical records that illustrate the need for the requested PAS hours.

- Discuss any change (or lack of change) in your patient's functional status. If your patient is appealing a reduction in PAS hours, be sure to state that there has been no change/ improvement in their condition. For patients who are seeking new or additional hours, explain any decline in their functional status or changes in their circumstances that are causing them to need additional PAS.

- Explain why the PAS hours approved by the CHC Plan would not be enough to meet your patient's needs. *Example: " The 49 PAS hours per week approved by [CHC Plan] would not adequately provide for Mr. Williams' toileting and incontinence care. Mr. Williams goes to the bathroom 8-10 times per day at unscheduled intervals, including 2-3 bathroom visits where his caregivers have to change his Depends because he has had an incontinence episode."*

- Discuss any ways your patient's health or safety would be jeopardized if their PAS hours are reduced (or not increased). *Example: "If Ms. Jones' PAS hours are reduced to just [XX] hours per week, she would be at increased risk of . . . because . . ."*

- PAS includes "supervision to assist a participant who cannot be left safely alone." Highlight any safety concerns that require ongoing supervision of your patient, such

as wandering/elopement, falls, or seizures. If possible, provide specific examples or explain the frequency of these concerns. *Example: "Sam has had at least two falls over the past six months, and reports that their caregivers have to steady them at least 1-2 times per day to prevent them from falling when they start to lose their balance."*

- PAS also includes cueing to prompt a participant to perform a task. Explain any cognitive or memory impairments, if applicable, and be sure to identify any activities where your patient requires cueing or prompting, even if they don't require physical assistance.

- Discuss your patient's overnight needs, if applicable. These might include turning/repositioning and assistance or supervision with toileting

Step 5: Restate your Conclusion

Conclude with restating your opinion that the requested PAS hours are (or continue to be) medically necessary for your patient, and asking the CHC Plan to authorize the requested hours in full.

Step 6: Proofread

Take a few minutes to proofread your letter for spelling and grammar mistakes. Also be sure that you've included pertinent details about your patient such as the correct diagnoses, and their date of birth or other identifying information.

Step 7: Sign, Date and Deliver

Fax your signed and dated letter to your patient's Community HealthChoices (CHC) health plan. *ALSO share a copy of the letter with your patient (and/or their advocate)* so they can include it with any other materials they are submitting for their appeal. Here are the fax numbers for the CHC Plans:

- AmeriHealth Caritas/Keystone First: 1-855-332-0141, ATTN: Participant Appeals
- PA Health & Wellness: 1-844-873-7451, ATTN: Complaints and Grievances Unit
- UPMC: 412-454-7920, ATTN: Complaints, Grievances and Appeals

For more information on writing a letter of medical necessity, please call PHLP's Helpline at 1-800-274-3258 or e-mail staff@phlp.org.