

**Date:** [Insert Date]

**To:** [Insurance Company Name]

**Attention:** Utilization Management / Medical Review Department

**Address:** [Insert Address]

**Fax/Phone:** [Insert Fax/Phone Number]

**RE: Letter of Medical Necessity for Skilled In-Home Nursing**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Patient DOB]

**Policy/Member ID:** [Member ID Number]

**Claim/Reference Number:** [If applicable]

To Whom It May Concern,

I am writing to provide a formal Letter of Medical Necessity for [Patient Name] regarding the requirement for skilled in-home nursing services for complex wound care management. [Patient Name] is currently under my care for the treatment of [Primary Diagnosis/Wound Type, e.g., Stage IV Pressure Ulcer, Non-healing Surgical Site].

**Clinical Documentation:**

The patient presents with the following clinical indicators necessitating professional intervention:

- **Wound Description:** [Insert dimensions, location, depth, and stage/grade].
- **Exudate/Drainage:** [Describe level and type of drainage].
- **Complications:** [Mention presence of infection, necrotic tissue, tunneling, or undermining].
- **Relevant History:** [List comorbidities such as Diabetes, Peripheral Vascular Disease, or limited mobility].

**Required Interventions:**

The complexity of the wound requires professional nursing skills that cannot be safely performed by a layperson or caregiver. These services include:

- Debridement of necrotic tissue.
- Application of prescription topical agents and specialized dressings (e.g., Negative Pressure Wound Therapy).
- Sterile dressing changes to prevent systemic infection or sepsis.
- Ongoing assessment of wound bed granulation and periwound skin integrity.

**Medical Necessity:**

Skilled in-home nursing is medically necessary to prevent further clinical deterioration, avoid hospital readmission, and manage the risk of osteomyelitis or sepsis. Given the patient's [mention barriers, e.g., inability to transport to a clinic, severity of pain], in-home care is the most appropriate and cost-effective setting for these treatments.

**Treatment Plan:**

I am prescribing skilled nursing visits [Number of times] per week for a duration of [Number of weeks/months]. Progress will be re-evaluated at the end of this period.

Please contact my office at [Phone Number] if you require additional clinical records or clarification.

Sincerely,

[Physician Signature]

**Physician Name:** [Print Name]

**NPI Number:** [NPI Number]

**Facility/Clinic Name:** [Clinic Name]