

Date: [Insert Date]

TO: [Insurance Company Name]

ATTN: [Department/Claims Appeals]

FAX/ADDRESS: [Insert Fax Number or Address]

RE: Letter of Medical Necessity for Orthotic Intervention

Patient Name: [Patient First and Last Name]

Date of Birth: [MM/DD/YYYY]

Member ID: [Insert ID Number]

Group Number: [Insert Group Number]

To Whom It May Concern,

I am writing to formally request coverage for custom-fabricated/pre-fabricated orthotics for the aforementioned patient. I have been treating this patient since [Date] for **Severe Osteoarthritis** (ICD-10 Code: [Insert Code, e.g., M19.0]).

Clinical Diagnosis and Findings:

The patient presents with advanced joint degeneration in the [Specify location, e.g., medial compartment of the knee/bilateral ankles]. Physical examination and imaging (X-ray/MRI) confirm severe joint space narrowing, bone-on-bone contact, and significant inflammation. The patient experiences chronic pain, joint instability, and a severely limited range of motion.

Functional Limitations:

Due to the severity of the osteoarthritis, the patient is experiencing difficulty with activities of daily living (ADLs), including walking short distances, climbing stairs, and [Insert other limitations]. Without proper orthotic support, the patient is at a high risk for falls and further structural deformity.

Previous Treatments:

To date, the following conservative treatments have been attempted with insufficient results:

- Physical Therapy
- NSAIDs/Pharmacological management
- Corticosteroid injections
- Over-the-counter bracing/inserts

Recommendation:

I am prescribing [Specific Type of Orthotic, e.g., Custom Unloader Knee Brace or Custom Foot Orthotics]. These devices are medically necessary to:

- Realign the joint to reduce bone-on-bone friction.
- Offload pressure from the affected compartment.
- Provide stability to prevent further joint degradation.
- Delay or prevent the need for invasive surgical intervention (Total Joint Replacement).

Please contact my office at [Phone Number] if you require additional clinical documentation or imaging reports.

Sincerely,

[Physician Signature]

[Physician Printed Name]

NPI Number: [Insert NPI]

Practice Name: [Insert Practice Name]