

**Date:** [Date]

**To:** [Insurance Company Name]

**Attn:** Medical Review/Appeals Department

**Fax/Address:** [Fax Number or Address]

**RE: Letter of Medical Necessity for Custom Spinal Orthosis**

**Patient Name:** [Patient Name]

**Date of Birth:** [DOB]

**Policy ID:** [Member ID]

**Group Number:** [Group Number]

**Reference/Authorization Number:** [Reference Number if applicable]

To Whom It May Concern,

I am writing to formally request coverage for a custom-fabricated spinal orthotic (HCPCS code: [Insert Code, e.g., L0637, L0456]) for the above-mentioned patient. This device is medically necessary to treat [Patient's Primary Diagnosis/ICD-10 Code].

**Clinical History and Diagnosis:**

The patient presents with [Describe condition, e.g., Grade II Spondylolisthesis, Acute vertebral compression fracture, Severe scoliosis]. The patient's current symptoms include [Describe symptoms, e.g., chronic radiating pain, spinal instability, restricted mobility].

**Treatment Rationale:**

A custom-fabricated device is required rather than an off-the-shelf (OTS) orthosis for the following reasons:

- [Reason 1: e.g., Unique anatomical deformity that cannot be accommodated by standard sizing]
- [Reason 2: e.g., Need for specific three-point pressure system to prevent further curvature]
- [Reason 3: e.g., Requirement for maximum immobilization following surgical intervention at levels X through Y]

**Previous Interventions:**

The patient has previously attempted [List failed treatments, e.g., physical therapy, OTC bracing, injections] without sufficient improvement in stability or pain reduction.

**Duration of Use:**

The patient is expected to wear this device for [Number of months/weeks] for [Number of hours] per day. This device is essential to [Goal: e.g., prevent surgical intervention, facilitate post-operative healing, prevent neurological deficit].

I request that you approve the coverage for this custom spinal orthosis. Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]