



LETTER OF MEDICAL NECESSITY

Patient Name:	SSN: _____ - _____ - _____	
Address:		
City:	State:	Zip:

I am writing on behalf of the above named patient regarding patient self-testing of anticoagulation status with fingerstick prothrombin time (PT) testing. The patient's condition requires anticoagulation therapy to reduce the risks of thromboembolic complications. Thrombosis can result in clots forming or traveling to the brain or lung with serious adverse medical results, which in some cases can be life threatening. By using at-home monitoring, the patient will benefit with increased time in therapeutic range and is less likely to be a risk for complications resulting from anticoagulation therapy.

I believe that patient self-testing is medically necessary for the care of this patient as summarized below;

Diagnosis	Code	Diagnosis	Code
<input type="checkbox"/> Mechanical heart valve <input type="checkbox"/> Aortic <input type="checkbox"/> Mitral	V43.3	<input type="checkbox"/> Antiphospholipid syndrome	795.79
<input type="checkbox"/> Atrial fibrillation	427.31	<input type="checkbox"/> TIA	453.9
<input type="checkbox"/> Atrial Flutter	427.32	<input type="checkbox"/> Clotting disorder	286.9
<input type="checkbox"/> DVT (deep vein thrombosis)	453.8	<input type="checkbox"/> CVA	436.0
<input type="checkbox"/> Pulmonary emboli	415.1	<input type="checkbox"/> Congestive heart disease	428.0
<input type="checkbox"/> Multi-thrombophlebitis	451.9	<input type="checkbox"/> Cardiomyopathy	425.4
<input type="checkbox"/> Valve insufficiency	376.1	<input type="checkbox"/> Peripheral vascular disease	443.9
<input type="checkbox"/> Protein S deficiency	289.81	<input type="checkbox"/> Hypercoagulable disorder	289.8
<input type="checkbox"/> Protein C deficiency	289.81	<input type="checkbox"/> Lupus	710.0
<input type="checkbox"/> Other		<input type="checkbox"/> Budd Chiari syndrome	453.0

Complications and Aggravating Circumstances		
<input type="checkbox"/> Hospitalizations: # _____ Last date admitted: ____/____/____ Previous date admitted: ____/____/____		
<input type="checkbox"/> Unstable INR- % time out of range _____	<input type="checkbox"/> Child	<input type="checkbox"/> Lab/clinic not accessible due to travel
<input type="checkbox"/> Venipuncture difficulty	<input type="checkbox"/> Infant	<input type="checkbox"/> Extensive travel
<input type="checkbox"/> Elderly/frail	<input type="checkbox"/> Requires frequent testing	<input type="checkbox"/> Homebound
<input type="checkbox"/> Condition precludes travel for testing	<input type="checkbox"/> Remote location	<input type="checkbox"/> Long-term anticoagulation therapy
<input type="checkbox"/> Major bleed history	<input type="checkbox"/> Slow lab results	<input type="checkbox"/> Other: _____
Comorbidities		
<input type="checkbox"/> Diabetes <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> COPD <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Other: _____		

<input type="checkbox"/> Patient on warfarin therapy. Explain: _____ _____ _____ _____

(Attach a separate sheet of explanation if necessary)

The patient (patient's caregiver) is fully capable of performing these tests, understanding the implications of the test results, contacting our office as directed to review the test results, and making adjustments to anticoagulation therapy as directed. For these reasons, I believe that patient self-testing is reasonable and necessary for this patient, and it should be covered. If you require additional information, feel free to contact me.

Physician Signature _____ **Date:** ____ / ____ / ____

PLEASE FAX TO: 407-563-2861

Quality Assured Services, Inc.

1506 N. Orange Blossom Trail Orlando, Florida 32804-6103 800-298-4515 Fax: 407-563-2861