ZIMMER BIOMET
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Payer Coverage Approval Process Guide

Market Access

You've got questions. We've got answers.

Insurance Verification Process

Eligibility And Benefits Verification

Understanding and verifying a patient's insurance eligibility and benefits is a critical process prior to treatment. The eligibility and benefits verification process involves the following three steps:

1. Verifying the patient's insurance eligibility and benefits prior to treatment by contacting the payer's provider line number that appears on the patient's insurance card
2. Checking with the payer regarding any patient payment responsibilities including co-payments, deductibles, co-insurance and any other out-of-pocket expenses prior to and post treatment
3. Informing the patient of their payment responsibilities at the time of appointment scheduling. This step is beneficial to both the patient and the HCP. It helps the patient decide on the course of treatment and the HCP to avoid last minute cancellations

It is important to gather and document information during the insurance verification process for future reference; especially, insurer contact information, the patient's financial responsibilities and prior-authorization approval numbers.

Information That Should Be Obtained From The Insurer And Documented For Future Reference Include

- Name of insurance representative, including phone number and extension
- Note date and time of call
- Patient's health plan effective and/or termination date
- Type of health plan (HMO, PPO, POS, etc.)
- Patient's financial responsibilities (i.e. co-payment, deductible, out-of-pocket expense)
- In- and out-of network benefits – This information is important to know because if the treating physician is an out-of-network provider and the plan does not allow out-of-network provider services, the patient may have to seek an in-network provider to perform the procedure. Not knowing this information could lead to a claim denial
- Verification of medical benefits for treatment
- Prior-authorization requirements, if any, including contact information (contact name, telephone, fax number)
- Referral requirements, if any, including telephone number and fax number to submit a signed and dated referral from the primary care physician or other referring physicians.

Predetermination

Predetermination is a process established by health plans that allows a physician to submit a treatment plan prior to surgery. The health plan reviews the treatment plan as well as the patient's insurance benefit plan and medical policy to determine:

- if the treatment is covered
- if the patient is a covered member
- the amount of copayments/coinsurance, deductibles, and the patient's maximum benefits.

This process is typically used to simply verify benefits, but it can be an effective tool to use with health plans for new technologies for which you expect coverage to be an issue.

Predetermination Process

Planning Your Predetermination Benefit Strategy

Be Proactive: Determine if the surgical procedure and technology you plan to use are covered under your patient's benefit plan.

Predetermination reviews vary between insurance plans, with varying timelines and requirements. But in general the predetermination process, if available, allows the health plan to determine if the patient's plan covers the surgery. If the implants are considered "new technology", the predetermination process can provide a mechanism for the plan's Medical Director to review it and determine if the technology is covered. If the health plan or Medical Director reviews this information and decides the technology is covered and medically necessary, you should not encounter significant problems obtaining an authorization.

Here is a list of tasks to help you develop a predetermination packet:

- Request the predetermination of benefits process or requirements from the patient's insurance plan
- Obtain the name of a contact person
- Verify the health plan's mailing address
- Obtain the Medical Director's name, phone number and specifically ask the Medical Director to review your request. [Note: A Medical Director's review may eliminate some of the difficulties you might encounter during the prior authorization process, especially if you are requesting use of a new technology. The Medical Director will often provide guidance about what additional information may be needed.]
- Obtain published studies from the Zimmer Biomet Reimbursement Hotline representative to support your request
- Be an advocate for your patient: describe how the technology can benefit this specific patient
- Include surgeon's availability, contact information and willingness to speak with the Medical Director about this matter

The Predetermination Request

Compose a letter of medical necessity addressed to the Medical Director

- Patient information — name, date of birth, policy number
- Details of the patient's medical history
  - Current diagnoses, billing codes, and reason for treatment
  - Duration and degree of illness and injury
  - Summary of past failed treatments (i.e., conservative care or other surgical interventions)
  - Description of the patient's current condition and treatment plan
    - Ability to work
    - Activities of daily living
- Proposed procedure(s), technology (medical device/ implants if applicable) and rationale for treatment
- Proposed location of service and dates planned
- Summary of the clinical evidence supporting your treatment plan including comorbidities

Additional Elements to Include with Your Predetermination Request

- Published studies supporting your treatment plan
- Product information
- FDA approval letter (helpful in certain situations; e.g., new technologies)
- Copy of the patient's insurance card
- Physician dictation regarding patient's history and current medical condition
- Results of diagnostic tests

Once the predetermination request is complete, submit it to the health plan. If you have not received a response within 30 days, follow up with the health plan by phone.

Prior Authorization Process

Medicare

The Medicare program does not provide prior authorization, prior approval or a predetermination of benefits for any services. General coverage guidelines for many services can be found using the Medicare Coverage Database. The database is maintained by CMS and is located on their web site at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. In the absence of a local or national coverage determination, the local Medicare Administrative Contractor (MAC) will determine whether coverage is available for a service on a case-by-case basis.

An HMO Medicare Advantage program most likely will require prior authorization of specified services. Please verify prior authorization guidelines with the payer.

Private Payer

The requirements of private payers for prior authorization vary. Certain payers may require the health care provider to submit specific patient information for medical review. It is important to become familiar with each payer's prior authorization guidelines.

Prior authorization means that the insurer has given approval for a patient to receive treatment, a test or surgical procedure before it has actually occurred. A prior authorization approval does not guarantee payment.

To prior authorize a procedure before services are rendered, provide the following information to the payer's prior authorization department:

- Diagnosis code(s)
- Procedure (CPT) code(s)*
- Description of the procedure
- Product-specific description, if required
- Any additional information requested by the prior authorization department related to the patient's condition and procedural clinical evidence

A written prior authorization request may be required by the payer. This requirement may vary by payer. Some insurers may require the submission of their own prior authorization request form or a letter from the treating physician. The prior authorization request should include the following detailed information about the patient's medical condition and the reason for the patient to undergo treatment:

- The patient's medical condition with exact diagnosis and symptoms associated with the disease
- The medical necessity for the treatment and what health problems may occur if the patient does not undergo the procedure
- What other treatments or services the patient has already had, if any, and why these alternative treatments did not alleviate the symptoms
- A description of the treatment
- Why the procedure is the most appropriate treatment for the patient's condition

Typically, most payers will respond with a decision within 30 days. The health plan is required to provide a clinical reason for their decision, and whether they are approving or denying the request. If the prior authorization is approved, document the approval number in the patient's chart should any questions arise at a later date.

Worker's Compensation

Worker's compensation (worker's comp) insurance provides compensation for employees who are injured during the course of employment. It provides reimbursement for medical expenses. Worker's comp benefits are administered on a state level primarily by the State Department of Labor.

Worker's compensation prior authorization rules are state-specific. Please contact your local carrier for a list of services that require prior authorization as well as state-specific instructions.

Appealing Denials

An appeal is a request for review of a denied claim or service. Claims may be denied for many reasons, including the result of health plan errors, inaccurate patient or claim information submission, and/or inaccurate coding or health plan coverage policy. Prior authorization is typically denied because the payer could not determine the medical necessity and appropriateness of the proposed treatment, level of care assessment and/or appropriate treatment setting, or the services are deemed experimental or investigational.

The reason for the denial can be found in the denial letter and/or the explanation of benefits (EOB). If a claim or service is denied, an appeal may be filed with the insurance carrier.

Depending on the payer, the level of appeal may be considered a reconsideration, redetermination, grievance or an appeal. Each payer may have differing administrative requirements for each of these depending on their own definitions. Because payers have different appeal processes, we suggest contacting the payer directly to verify their appeal requirements.

Some payers have specific forms, phone numbers and addresses that must be used to submit an appeal. Please contact your payer to see if there is a specific appeal process that should be followed. Payer-specific guidelines for appeals may also be found online. If a payer has a standard appeal form, fill it out and submit it with all other supporting documentation that proves the need for coverage.

The following are some suggested questions to ask the insurance representative regarding their specific appeals process:

- Does the appeal request have to be completed by the health care provider or the patient?
- Is there a particular form that needs to be completed?
- Can this form be faxed or mailed?
- If faxed, what is the fax number?
- If mailed, what is the appropriate address?
- Is a letter of medical necessity required?
- What is the time limit for requesting an appeal?

When requesting a review of the denied claim or service, the request must meet the following requirements:

- The request must be in writing
- Include reasons why the denial is incorrect
- Include any new and relevant information not previously submitted, such the procedure dictation notes
- Must be requested within the period of time allotted by the payer's guidelines. Please be advised that the appeal guidelines and timeframes are provided in the letter of denial. If the denial letter is not readily available, contact the payer's appeal department for instructions

If the payer does not have a required appeal form, submit an appeal letter. The appeal letter should be tailored to the reason for the denial and may include a corrected claim, product information, patient medical information, clinical data, and/or economic data along with other supporting documentation.

CMS defines medical necessity as those services that are reasonable and necessary for the diagnosis or treatment of an illness or injury. The term medical necessity is usually used to determine whether or not a procedure or service is covered by CMS. The appropriate diagnosis, treatment and follow-up care plan, as determined and prescribed by the HCP, should fit the patient's specific diagnosis. To establish medical necessity, the physician must clearly describe the condition(s) that justify the medical service provided.

The more complete and detailed an appeal is, the more successful it is likely to be. That is, the specificity of the medical necessity information and the documentation provided are keys to the success of the appeal. It is critical to the appeal process that the HCP attach any medical documentation that may support the medical necessity of the services being provided.

The supporting medical documentation listed below are examples of the types of information that may be submitted in order to support the claim for payment or a service for approval:

- Physician's orders
- Medical history
- Physician's notes/nurse's notes
- Procedure dictation notes
- Test results
- X-ray reports
- Consultation reports
- Plan of treatment
- Referrals
- Product information
- Specific reasons the physician believes that the use of the specific therapy/product is medically necessary
- Relevant clinical data
- List of conservative or alternative treatments that failed
- Discharge notes

If the claim or service is denied by the insurer's internal department and the intent is to continue the process of either obtaining a prior authorization or appealing a denied claim, state-specific and payer-specific guidelines must be followed to elevate the appeal to a higher level. The type of insurance determines whether federal or state laws apply to the appeal process. If the plan is self-funded through an employer group then the Employee Retirement and Income Security Act (ERISA) applies and the Department of Labor has jurisdiction. If it is commercial insurance, state law applies and the state Division of Insurance (DOI) has jurisdiction.

Zimmer Biomet Reimbursement Hotline
Phone: 1.866.946.0444
Fax: 877.211.7271
E-mail: reimbursement@zimmerbiomet.com
Available Monday – Friday, 8 a.m. – 5 p.m. EST

The Zimmer Biomet Reimbursement Hotline is a support hotline staffed by reimbursement specialists including a certified coder to answer questions regarding coding and reimbursement. The Zimmer Biomet Reimbursement Hotline is designed to assist health care providers and their staff by providing reimbursement assistance for Zimmer Biomet technologies.

The Zimmer Biomet Reimbursement Hotline can assist in the following areas:

- Share insurance guidelines for commercial and government health programs
- Assist providers on payer specific claims submission requirements
- Evaluate claim denial reasons and provide assistance with appeals.
- Provide published CMS fee schedules and payment process methodologies
- Provide coding information specific to payer requirements and coding guidelines

The Zimmer Biomet Reimbursement Hotline cannot:

- Submit a claim
- Guarantee coverage or specific payment level
- Recommend what providers charge for Zimmer Biomet products
- Tell the provider what codes should be used to "maximize" reimbursement

This reimbursement guide is effective January 1, 2018

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